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SATISFACTION AND DISSATISFACTION AS PERCEIVED BY ELDERLY CLIENTS ON HOME CARE

BY ©

DOROTHY ANNE FORBES

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF NURSING.

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled SATISFACTION AND DISSATISFACTION AS PERCEIVED BY ELDERLY CLIENTS ON HOME CARE submitted by DOROTHY ANNE FORBES in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

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DEDICATION

To the clients on home care who have contributed to my understanding of the meaning of life by willingly sharing their lived-experiences.

ABSTRACT

Client satisfaction with care received has become one of the valued outcome indicators, even an element of health status itself (Donabedian, 1988). However, before client satisfaction with home care can become a useful outcome indicator, the dimensions and boundaries of this construct must be defined. The purpose of this study was to examine what elderly clients perceived as being important in relation to their satisfaction and/or dissatisfaction with home care. An exploratory design was utilized. A purposeful sample was selected from clients enrolled on two urban-rural Home Care Programs located in central Alberta, Canada. The sample size was 10. The primary methods of data collection were two guided interactive interviews using open-ended questions, story telling, scenarios and rating in importance the dimensions of client satisfaction and dissatisfaction.

A hierarchical thematic analysis revealed 16 categories of themes. The dimensions of satisfaction with home care were found to be influenced by clients' expectations; structural aspects of home care, such as consistency, accessibility, availability and flexibility; and attributes of the formal providers of care, such as cheerfulness, sensitivity to the clients' needs, and trustworthiness. In addition, clients' relationships with the formal providers of care and their involvement with the planning of their care were identified as influencing their satisfaction with home care. These same elements, if lacking appeared to result in dissatisfaction with home care. Absence of information and/or understanding contributed to dissatisfaction. As well, client characteristics such as values, goals, perceived limitations and perceived social support all influenced their perceptions of satisfaction/dissatisfaction with home care.

The findings indicate that the outcomes, satisfaction and dissatisfaction are multidimensional constructs. Since the same elements influence both satisfaction and dissatisfaction, these constructs appear to be at opposite ends of several continua of multiple dimensions. The identified elements which enhance client satisfaction may be incorporated in the delivery of care by nurses and by their partners in health care. Although further research is required to fully understand the constructs of satisfaction and dissatisfaction, the findings in this investigation provide a sound basis for the refinement or development of a client satisfaction instrument.

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I. INTRODUCTION

Statement of the Problem

With the high cost of health care, interest in outcomes research has been generated at all levels, locally, provincially, nationally and internationally. Indeed, partners in health care are being forced to account for what they do: the efficiency of their interventions and the effectiveness of their outcomes. However, only when outcomes research includes the consumers' perspective will a complete picture be obtained (Miller Bader, 1988). Client/patient satisfaction with care received has become one of the valued outcome indicators, even an element of health status itself (Donabedian, 1988). The emphasis on client/patient satisfaction has been fuelled by consumers themselves who demand and expect quality health care. Alberta Health, recognizing the value of achieving client/patient satisfaction, has encouraged the implementation of concepts such as Total Quality Management or Continuous Quality Improvement that focus on meeting and exceeding customer satisfaction (Diduck, 1991). As well, in Alberta, financial support for outcomes research has increased with the current focus of the Health Services Research and Innovation Fund on health outcomes and the effectiveness of health services. As a further incentive, an Outcomes

Strategy Working Committee of the Acute Care Funding Plan was recently struck to develop a means by which outcomes can be incorporated into the funding formula (Alberta Health, 1993).

Because of the need to reduce health care expenditures, reform of the entire health care system is occurring with a shift in emphasis from institutional care to community-based care. As a result, Alberta's Home Care Program, which is currently the leading provider of community care, will assume new and increasingly important roles in easing pressures in the health system (Alberta Health, 1992). Not only will home care clients require heavier and more complicated care than ever before, but the recipients of home care services are often the most vulnerable clients in our society, as they are frail elders who are hidden in their homes away from public view (Applebaum & Phillips, 1990). It is essential that strategies be developed to ensure the provision of quality care and to measure client outcomes, including client satisfaction with home care. However, before client satisfaction with home care can be valued as an outcome indicator, the dimensions and boundaries of the construct of client satisfaction must be clearly defined.

Purpose

The purpose of this study was to examine what elderly clients perceived as being important in relation to their satisfaction and/or dissatisfaction with home care. Additionally, the characteristics of clients which may influence their perceptions of satisfaction and/or dissatisfaction were explored. Research questions were developed to guide the study.

Research Questions

Specifically, the research questions which guided this study were: 1) what do elderly clients perceive as being important in influencing their satisfaction with home care; 2) what do elderly clients perceive as being important in influencing their dissatisfaction with home care; and 3) to what extent do the constructs satisfaction and dissatisfaction appear to be similar or different?

Definition of Terms

In this research study the following terms are defined as:

1) client - enrolled in a home care program and the recipient of care;

2) satisfaction with home care - clients' perceptions about home care services and formal care providers which have been presented as positive;

3) dissatisfaction with home care - clients' perceptions about home care services and formal care providers which have been presented as negative.

Significance of the Study

Understanding the dimensions and boundaries of the constructs client satisfaction and dissatisfaction are the first steps in defining and in building a theory of client satisfaction. As well, the broad array of themes which were generated from this study may be compared to the themes addressed in existing satisfaction questionnaires and if necessary, used to develop a new instrument. As only clients themselves can relate their experience with home care and identify what is important in influencing their satisfaction and/or dissatisfaction with home care, it is imperative to conduct a study such as this prior to the development of satisfaction tools. Any development of a client satisfaction instrument without consumer input would have questionable validity (Hulka, Kupper, Daly, Cassel, & Schoen, 1975). Only when instruments are judged to be reliable and valid in measuring the dimensions of satisfaction, will organizations such as home care consider client satisfaction to be an indispensable indicator of quality of care. As nursing comprises the largest professional discipline within home care, nurses, as well as other professional and support workers, are interested in determining clients' satisfaction with home care.

By measuring and improving satisfaction, clients are more likely to participate in their own care and to cooperate with their care providers by disclosing relevant information and by adhering to prescribed treatment regimes (Petersen, 1989; Weiss & Ramsey, 1989). Haq (1988) demonstrated a low positive relationship between health motivation and satisfaction with primary care in elderly clients who received services at a nursing centre. In addition, the satisfied client is a major "marketer" for the health care agency as it has been reported that satisfied customers will relate their satisfaction to 4 to 5 other people; dissatisfied customers will relate their dissatisfaction to 9 to 10 other people (Meisenheimer, 1991). Furthermore, client satisfaction data may be useful for risk management purposes, as potential as well as actual problem areas may be revealed which require review and proactive/reactive planning. For all of these reasons, it is essential that the construct of satisfaction and dissatisfaction be understood, clearly defined and accurately measured.

II. REVIEW OF THE LITERATURE

Clients/patients are the central focus of the health care system. Yet until recently their perceptions were generally considered external to the process of care delivery. With the emphasis on fiscal restraint and outcome measurement there has been an increased interest in the significance of consumers' views. Indeed, there has been an abundance of satisfaction research since the 1980's.

While there continues to be disagreement about how to define the construct satisfaction, the dimensions of satisfaction, the purpose for measuring satisfaction, the determinants of satisfaction and the instruments to be used, it is generally agreed that satisfaction is a multidimensional construct (Hulka et al., 1975; Ware & Snyder, 1975) and should be context specific (Carr-Hill, 1992; S.J. Williams & Calnan, 1991a; Zastowny, Roghmann, & Cafferata, 1989). For this reason, a brief overview of satisfaction research is presented according to the setting: acute care, long term care facility, ambulatory care, community and home care. Findings from these studies which are relevant to the thesis are highlighted. A discussion follows of the determinants of satisfaction, and the absence of a sound theoretical base which creates inconsistencies in conducting satisfaction research. The common methodological problems encountered are also delineated.

Setting

Acute Care

Patient satisfaction has been studied extensively in acute care settings. This research has been conducted to measure patient satisfaction with: a number of services, such as admissions, food service, housekeeping, nursing, medical and/or ward environment (Carey & Posavac, 1982; Carmel, 1985; Forgan Morle, 1984; Raphael, 1967; Shields, Morrison & Hart Sen, 1988); nursing care (Abramowitz, Cote, & Berry, 1987; Elbeck, 1986; Eriksen, 1988; Simpson, 1985); physician care (Blanchard, Labrecque, Ruckdeschel, & Blanchard, 1990; Ware, & Snyder, 1975); an emergency department (Hunt & Glucksman, 1991); interventions or programs such as discharge planning programs (Haddock, 1988; Siders, & Peterson, 1991); promptness of service (Hildman, & Ferguson, 1990); an organizational mode (Greenley, & Schoenherr, 1981; Long, Blackwell, & Midgley, 1992; Pope, 1978); hospital care versus outpatient care (Gamotis, Dearmon, Doolittle, & Price, 1988; Seckler, & Held, 1990) and home care (White, 1992); and between hospitals (Goupy, Ruhlmann, Paris, & Thelot, 1991; Moores, & Thompson, 1986). Thus, it can be seen that although these studies were all conducted within an acute care setting the focus of the research varied extensively.

The majority of these studies utilized surveys. However, two studies conducted open-ended interviews as well as administering questionnaires (Forgan Morle, 1984; Haddock, 1988). The instruments used rated aspects of care defined and held to be important by the professionals and care givers which are not necessarily important from the patients' perspective (Sullivan & Yudelowitz, 1991; M. White, 1972). Notable exceptions were the studies conducted by Moores and Thompson (1986) and Shields et al. (1988), in which the development of the questionnaires were guided by semi-structured interviews.

One study utilized a qualitative approach. Hansson, Bjorkman, and Berglund (1993) mapped descriptive characteristics of ideal inpatient psychiatric care by interviewing 78 hospitalized patients. Results of the content analysis showed that characteristics of ideal inpatient treatment could be classified in six categories: staff-patient relationship, patient co-influence, treatment content, activities, ward atmosphere and staff competence. Another sample of 77 patients ranked the importance of the 48 treatment characteristics extracted from the qualitative analysis. The results showed that patients put the highest emphasis on staff empathic qualities and the least importance to characteristics of the physical environment and daily routines on the ward.

Some of the results from the studies conducted in acute care settings exemplify the contradictory findings related to biographical variables, which have led some investigators to dismiss these variables as reliable predictors of satisfaction (Fox & Storms, 1981). For example, Hildman and Ferguson (1990) found men were to rate nursing services lower than women, whereas Simpson (1985) determined that men scored their care higher than women and that the elderly were most dissatisfied. However, Blanchard et al. (1990) found the elderly to be the most satisfied. A more thorough description of the determinants of satisfaction as revealed by these studies is discussed in a following section.

Dissatisfaction in an emergency department was found to be related to attitude, missed diagnosis, waiting time, cursory examination and poor communication (Hunt & Glucksman, 1991). Higher levels of satisfaction were found to be associated with: the absence of bureaucratic rigidity in staff procedures (Greenley & Schoenherr, 1981); outpatient care as compared with inpatient care (Gamotis et al., 1988; Seckler & Held, 1990); and home care as compared to hospitalization (While, 1992). In addition, there was found to be a great range of satisfaction scores between hospitals (Goupy et al., 1991;

Moores & Thompson, 1986), and patients' and staff's perspectives of satisfying events were considerably different (Raphael, 1967).

Long Term Care Facilities

Similar findings were reported in a qualitative study of long-term residents of a psychiatric hospital. The results indicated that the physical surroundings were not important in determining satisfaction, however improvements in autonomy for the patients and a greater say in the running of wards were important in contributing to satisfaction with life in the hospital (Elzinga & Barlow, 1991). Two-hundred-and-eighty-nine residents in 51 nursing homes were surveyed to assess the influence of organizational factors on residents' satisfaction with the nursing home. Satisfaction was found to be related to the longevity of personnel, level of benefits, wages for nursing assistants and their perception of the charge nurse's fairness and competence as well as the degree of personalization of residents' rooms (Kruzich, Clinton, & Kelber, 1992). One wonders why the interpersonal relationships between the residents and the care providers are not explored to a greater extent in these studies.

Lavizzo-Mourey, Zinn, and Taylor (1992) compared questionnaire answers and concluded that nursing home residents' surrogates cannot accurately express the residents' satisfaction with all areas of nursing home care and that their evaluations should not be taken in lieu of the residents' opinions. However, a high percentage of residents in long term care facilities are cognitively impaired. Determining their satisfaction with care received is therefore extremely difficult. Perhaps, because of the difficulties encountered when assessing patients who are cognitively impaired, the majority of satisfaction research has been conducted in ambulatory care clinics.

Ambulatory Care Clinics

Patient satisfaction research has been studied extensively in ambulatory care settings. This research has focused on evaluating: day surgery (Read, 1990); specialty clinics (Bor et al., 1992; Cass & Kugler, 1993; Hill, Bird, Hopkins, Lawton, & Wright, 1992; Kelley, Alexander, & Morris, 1991; Sanchez-Menegay, Hudes, & Cummings, 1992); walk-in clinics (Parks, Cashman, Hemenway, & Bicknell, 1991); a rehabilitation department (Davis, & Hobbs, 1989); a social work department (Harkness, & Hensley, 1991); and physician practice behaviours (Robbins et al., 1993). All of these studies utilized questionnaires to assess patient satisfaction.

The results revealed that satisfaction with day surgery was high, and increased with age, although 24 percent reported problems such as infection after discharge (Read, 1990). This finding exemplifies the frequent failing of satisfaction research as the scores are usually high, yet patients express aspects of dissatisfaction. Least satisfaction was frequently reported in relation to access to care and continuity with the providers of care (Davis, & Hobbs, 1989; Hill et al., 1992; Kelley et al., 1991). Physician visit satisfaction was found to be positively related to previsit satisfaction, to time spent on health education, physical examination and discussion of treatment effects. There was a negative relationship with time spent on history taking (Robbins et al., 1993). In addition, patients' satisfaction with medical care was related to the degree of personal interest and reassurance they had received and to whether they felt they had received the right medication (Sanchez-Menegay et al., 1992).

Zastowny et al. (1989) suggested in their development of a conceptual model of satisfaction that a causal relationship between patient satisfaction and use of health services exists and is highly related to the provider from which patients seek care. The association of utilization and satisfaction of medical care is positive, (and sometimes significant), whereas in others it is negative (and sometimes significant). They conclude that global and structural characteristics of the medical care settings and specific patient experience need to be considered as factors in patient satisfaction. As well, the context in which the patient receives care must be examined as predictors of satisfaction, such as race and health status, are related to the setting. Whites were found to be generally more satisfied than blacks, but only in some settings was the effect found to be significant. Patients with a serious medical condition were found to be more satisfied in a teaching facility where "interesting cases" received more attention, whereas healthy individuals felt better care had been given in a clinic which was oriented to prevention. Cass and Kugler (1993) concur that structure, process, and outcome aspects of clinical practice should be assessed.

Community Setting

In comparison with acute care and ambulatory settings, a paucity of client satisfaction research exists which pertains to the community. The few studies which have been conducted in the community are in relation to evaluating: nurse practitioners (B.L. Chang, Uman, Linn, Ware, & Kane, 1984); occupational health nurses (Conbere, McGovern, Kochevar, & Widtfeldt, 1992); public health nurses (Field, 1984; Rovers, & Isenor, 1988; Schmele, 1985); public health nursing programs such as health promotion clinics/classes for the elderly (Laffrey, Renwanz-Boyle, Slagle, Guthmiller, & Carter, 1990; Rogers, Grower, & Supina, 1992) and antenatal/postpartum programs (Abriola, 1990; Gray, 1992; Redman, Oak, Booth, Jensen, & Saxton, 1991; L.R. Williams, & Cooper, 1993); nurse-managed clinics (Bagwell, 1987; Haq, 1988; Pulliam, 1991); and comparing community-based treatment programs with out-patient services for specific populations such as the mentally ill (Mangen & Griffith, 1982; G.A. Morse, Calsyn, Allen, Tempelhoff, & Smith, 1992).

A variety of methodologies were implemented in these studies. Questionnaires, developed for a particular study, were frequently administered (Bagwell, 1987; Conbere et al., 1992; Haq, 1988; Mangen, 1982; G.A. Morse et al., 1992; Redman et al., 1991). Open-ended interviews (Abriola, 1990; Field, 1984; Laffrey et al., 1990; Rogers et al., 1992), and focus group discussions (Pulliam, 1991) were utilized less frequently.

The results from these studies indicated a variety of factors which are important in determining satisfaction. These included: the support, information and opportunity to network provided by a postpartum support group (Abriola, 1990); the approachability and sympathetic nature of community psychiatric nurses (Mangen & Griffith, 1982); the location of a nurse-managed clinic in the participant's apartment building (Pulliam, 1991); blood pressure evaluation provided by a preventive health care program (Laffrey et al., 1990); and a continuous treatment team approach that included assertive outreach was more effective and satisfying than a drop-in centre or traditional outpatient treatment in serving the homeless mentally ill (G.A. Morse et al., 1992).

However, the majority of satisfaction research conducted in the community has been in relation to physicians and the provision of medical services (Hjortdahl & Laerum, 1992; Hulka, Kupper, Daly, Cassel, & Schoen, 1975; Korsch, Gozzi, & Francis, 1968; Kurata, Nogawa, Phillips, Hoffman, & Werblun, 1992; O'Sullivan, Mahoney, & Robinson, 1992; Tarlov et al., 1989; Ware, & Snyder, 1975; Wiggers, Donovan, Redman, Sanson-Fisher, 1990). Ware and Snyder (1975) used reliable index scores which met factor analytic criteria to identify four major dimensions of patient attitudes regarding their physicians and medical services: doctor conduct (humanness and quality/competence), availability of services, continuity/convenience of care, and access mechanisms. Other researchers concur with these dimensions (Hulka et al., 1975; Wiggers et al., 1990). Indeed, when patients' perceptions of the relationship with their physician were examined by asking 3,918 participants (78% responded) to complete a questionnaire, the findings indicated that: 1) the overall personal patient-doctor relationship increased the odds of the patient being satisfied with the consultation sevenfold; 2) the duration of the relationship had a weak but statistically significant association; and 3) the intensity of the relationship showed no association with patient satisfaction (Hjortdahl & Laerum, 1992). The importance of individualizing care is underscored by this study.

Telephone interviews with 156 adults revealed that the participants were least satisfied with access to medical care (Kurata et al., 1992). Lack of information from physicians was also frequently identified as an area of dissatisfaction. A survey of 503 mothers of disabled children indicated that the participants felt they had received insufficient information related to the effect of the child's disability on their development and family needs (O'Sullivan et al., 1992). By completing a questionnaire 232 ambulatory cancer patients reported they had received inadequate information concerning their disease, treatment, and symptom control and the provision of care in the home (Wiggers et al., 1990). An attitude questionnaire was completed by 1,713 adults. Blacks were found to be less satisfied than whites, the reverse was found in Bagwell's (1987) study which examined clients' satisfaction with nursing centre services. When asked to evaluate medical care, blacks over 60 years of age expressed negative effect towards costs and convenience, and young blacks reported negative attitudes toward the personal qualities of their physicians (Hulka et al., 1975). As this thesis examines client satisfaction with home care, a separate section is devoted to a review of the literature which pertains to this specific setting.

Home Care

The few studies which have been conducted in the home focused on clients' satisfaction with: a particular program such as home ventilator management (Hazlett, 1989), a collaborative posthospital program for the elderly (Edelstein & Lang, 1991), and a self-care intervention program (Albrecht et al., 1993); a specific treatment such as home intravenous antibiotics (Strandvik, Hjelte, Malmborg, & Widen, 1992); a mode of delivery of service such as primary nursing (Twardon, & Gartner, 1991); and a specific service such as homemaking (Eustis, & Fischer, 1991; Martin Matthews, & Wakefield, 1992a, 1992b; Samuelsson, Ingvad, & Edebalk, 1992) and nursing (McNeese, 1988; Reeder & Chen, 1990).

Comparison studies were also conducted which examined satisfaction with home care, a hospice program within a hospital setting and a conventional hospital (Dawson, 1991). One hundred bereaved familial care givers completed a mail questionnaire concerning their perceptions of care at the site of a family member's death. The findings indicated that home care provided the highest quality of basic needs satisfaction and the highest level of satisfaction with the nurse.

Satisfaction with basic in-home services was compared with a financial control model in which additional financial resources were available. Questionnaires were administered to 3,920 clients at baseline and then at 6-month intervals for 12 or 18 months. Surprisingly, clients were more satisfied with the provision of basic services. This suggests that it may not be the relative amount of financial resources available but rather the personal relationship with the case manager and the assistance provided with client-centred activities that directly enhanced client satisfaction (Rabiner, 1992).

A study undertaken in Finland examined the relationship between dissatisfaction with domiciliary care and insecurity. Security was defined as perceiving the environment as non-threatening and not worrying excessively about the future. As the feeling of security was strengthened, the ability to control one's own life increased (Neill, 1983). Insecurity may be related to discomfort or pain. A structured questionnaire with some open questions was administered to 344 clients. The results indicated that about one in ten clients were dissatisfied and insecure, with a statistically significant correlation between dissatisfaction and insecurity. The quality of the relationship with the provider of care was found to be the main predicting factor of the variance of dissatisfaction (Raatikainen, 1991).

Eustis and Fischer (1991) conducted in-depth interviews with 54 home care clients and their workers. Their results concur with Raatikainen (1991), as they concluded that the quality of the relationship between the client and homemaker affected the quality of care. Homemaker/client relationships were shown to be both formal and informal, in that job responsibilities tended to be diffusely defined and homemakers often became involved in the "backstage" world of their clients. Despite the implied closeness of the homemaker/client relationship, an inherent asymmetry in the relationship was noted. That is, clients were more likely to say that they could talk about their personal problems with their homemaker than homemakers were to say that they could confide in their clients. In addition, it was suggested that personal bonds may be problematic for both the workers and clients. The homemakers may feel exploited and the clients may feel loss of control over their own care.

Martin Matthews and Wakefield (1992b) supported the findings that informality, or personal bonding is a central feature of care in the home. Only 19% of the 155 elderly clients interviewed saw their homemaker as primarily an employee, while 47% saw her as primarily a friend, and 34% saw her as a combination of both friend and employee. When asked what "services" the homemaker provided, 95% reported light housekeeping and over 75% of the clients also reported companionship. Efficiency as a worker was not necessarily considered of value in the absence of a cheerful, companionate manner. Kaye (1986) in his study asked the homemakers of three home care programs in the United States what they perceived to be their clients' feelings of affection towards them. He concluded that elderly clients expect to receive additional affective and emotional support regardless of the nature of the service package which has been laid out for the homemaker to perform. Overall, Martin Matthews and Wakefield (1992b) found that 94% of the clients were either satisfied or very satisfied with the homemaking service. The personality of the homemaker was identified as a major factor contributing to satisfaction. Other sources of satisfaction were: the homemaker's competency and thoroughness in performing her job; the homemaker's trustworthiness; the fact that she required no direction; and "the little extras" that she did for the client. The concerns raised by the clients included: quality of service in terms of training; more information about appropriate services; and flexibility of service arrangements.

Elderly clients receiving home help services in Sweden were asked to rank in importance the quality attributes of the service. Continuity and personal relationships were identified as most important. Having influence over the home help's work was ranked as least important (Samuelsson, Ingvad, & Edebalk, 1992).

Even fewer studies have been conducted in relation to professional home care services. Reeder and Chen (1990) examined the nursing service provided to clients by a home health care agency in a rural county in east central Illinois. The visiting nurse left a survey with the clients who were instructed to complete and mail them back to the investigator. A small convenience sample of 48, resulted in a 77.1% useable response rate. Eighty-eight percent of the respondents were 65 years or older, and 96% had chronic diseases. The results indicated that clients' satisfaction was significantly associated with: how well the nurse listened to them; feeling better as a result of talking with the nurse; pleasantness of the nurse; and their satisfaction with the nursing care. The clients were least satisfied with: the nurses' attention to their needs; the nurse asking many questions, but then not seeming to do anything about their responses; and wishing the nurse would tell them about the results of tests or procedures.

McNeese (1988) examined clients' satisfaction with visiting nurses and home health aids. A survey was mailed to 300 clients with 57% responding. Questions were asked in relation to: 1) nurse-client communication; 2) patient teaching; and 3) nurse-client interpersonal relationship and trust. The results indicated that most clients were satisfied. The psychometric properties of the instrument used were not discussed.

Only one study was found in this beginning literature review which addressed a variety of services offered in a home setting. This study was completed by Alberta Health (1989a). A Home Care Client Outcome Tool (COT), which contains a client satisfaction questionnaire, was developed and pilot tested using a stratified random sample of 400 recently discharged clients. During the development of the COT, the modules were reviewed by the Standards Committee and were subjected to content validity by assessing how well they represented the universe they sampled. Construct validity was assessed to ensure that the outcome criteria and measurement modules were consistent with the values and objectives of the Home Care Program (Alberta Health, 1989a). The client satisfaction questionnaire addressed the following areas: satisfaction with home care, the services, staff's interpersonal skills, communication skills, confidence in staff, the amount of contact, continuity of care, participation in decision-making about home care and the impact of home care for the client. Outcomes for the client satisfaction questionnaire were very positive with 90% of the clients agreeing or strongly agreeing with the statements. Because of the few negative responses resulting in a non-normal bivariate distribution, validity could not be determined. Test-retest reliability was low to medium (Alberta Health, 1989b), however, no correlation coefficients were reported.

The Lethbridge Health Unit, Home Care Program (1991) used the client satisfaction questionnaire from the COT to determine whether switching from a contract model for providing nursing services to an in-house model where all nursing services were provided by home care case coordinators, had affected client satisfaction. The survey results of 110, 1989 home care clients who had received contracted nursing services were compared with the survey results of 150 clients who received in-house nursing services during 1991. There was found to be no overall change in satisfaction with nursing services, although significantly fewer clients were very satisfied. A pertinent finding from the 1991 survey revealed that only 40% of the clients reported that their nursing service was provided by the Health Unit and only 12% reported the Home Care Program, illustrating that the majority of clients were not aware that the nurses were employed by Home Care. Having presented an overview of satisfaction research, a discussion follows of the determinants of satisfaction which have been revealed from these studies.

Determinants of Client and Patient Satisfaction

Although many sociodemographic characteristics have been examined as determinants of satisfaction, few trends have been found. Hall and Dornan (1990) performed a meta-analysis of 221 studies and concluded that greater satisfaction with medical care was significantly associated with greater age and less education and marginally associated with being married and having higher social status. No overall relationship was found for ethnicity, sex, income, or family size. Cleary, Keroy, Karapanos, and McMullen (1989) found virtually no association between age and satisfaction and caution that age may be a stronger predictor for outpatient than inpatient studies, underscoring the importance of distinguishing the setting in which the research was conducted.

Positive correlations have been reported between client/patient satisfaction and: size of support network (Carmel, 1985); perceived social support (Raatikainen, 1991; Rabiner, 1992); perceived health status (Carmel, 1985; Cleary, Edgman-Levitan, McMullen, & Delbanco, 1992; Patrick, Scrivens, & Charlton, 1983; Pope, 1978; Raatikainen, 1991; Samuelsson et al., 1992); perceived life satisfaction (Olsen & Fylkesnes, 1991); positive past experiences with organizations (Carmel, 1985; Cleary & McNeil, 1988); access to care (Olsen & Fylkesnes, 1991); continuity of care (Hulka et al., 1975; Linn, 1975; Pope, 1978; Samuelsson et al., 1992; Weiss & Ramsey, 1989); participation in planning care (B.L. Chang et al., 1984; Simpson, 1985); and structure variables of patient need and nurse, doctor, clinic, and room time; and process variables of patient classification, time and complexity. A curvilinear relationship was found between patient need and patient satisfaction which indicated that patients with high needs were less satisfied with nursing care (Schada, 1988).

The relationship between the client and the formal care provider was frequently referred to in the literature as being a significant determinant of satisfaction.

Effective communication, attention to client needs, technical and interpersonal competence, and caring behaviours appear to be the strongest predictors of satisfaction (Hall, Roter, & Katz, 1988). In reviewing the satisfaction literature, Cleary and McNeil (1988) concluded that the most consistent finding is care which is more "personal" is associated with higher levels of satisfaction and resulted in feelings of greater control for the consumer (Taylor, 1988). Hauck, Zyzanski, Alemagno, and Medalie (1990) examined patients' perceptions of humanism in physicians and found a positive association with satisfaction. However, satisfaction with communication between patient and health care provider was often reported to be lower than satisfaction with other aspects of health care. Insufficient and conflicting information or inadequate explanations were frequently cited as dissatisfiers (Mangen & Griffith, 1982; Miller Bader, 1988; Oberst, 1984; Reeder & Chen, 1990; Richard, Sequin, Champagne, & Therrien, 1992; S.J. Williams & Calnan, 1991b; Wood, Corey, Freeman, & Shapiro, 1992).

Client expectations of care have also been found to be a significant determinant of satisfaction (Abramowitz, Cote, & Berry, 1987; Field, 1984; Hsieh & Kagle, 1991; Oberst, 1984; Pollert, 1971; E.J. White, 1988). For example, 10% of elderly patients reported that they required more help to perform a variety of tasks than was received from providers, but only 2% reported dissatisfaction. The respondents rationalized this inconsistency by stating that although the service did not meet their needs, the provider was doing all that could be expected (Locker & Dunt, 1978). Abramowitz et al. (1987) found that expectations of hospital care, together with satisfaction with nursing care accounted for 24% of the variance in overall satisfaction with hospital care.

Based on the findings from her exploratory study, Field (1984) formulated the following propositions: 1) clients who receive nursing care congruent with their expectations will feel satisfied with the nursing intervention, whether or not their problem has been solved; 2) clients who receive nursing care that is perceived as divergent from their general expectations will be ambivalent about or dissatisfied with their care even when progress toward their goal has been made; and 3) clients who cannot identify their problems or who have no definite expectation of the care will be ambivalent or dissatisfied with the care given. In addition, a bad surprise was shown to influence patient satisfaction more than a good surprise (E.C. Nelson & Larson, 1993). However, raising clients'/patients' expectations of care by increasing their involvement with their own care and by revealing their needs as identified by the assessment process, may in fact result in decreased satisfaction (Altschul, 1983; Greenfield, Kaplan, & Ware, 1985; Richards & Lambert, 1987).

Having provided an overview of satisfaction research and discussed the determinants of client/patient satisfaction as revealed in the literature, the question is raised: Has the measurement of client/patient satisfaction improved the quality of care? There appears to be no evidence in the literature that this has occurred (Vuori, 1991). Measurements of satisfaction with care received have not been considered a useful indicator of quality of care because of the absence of a sound theoretical base, the lack of standardized instruments and commonly encountered methodological problems. These are discussed in the following sections.

Theoretical Issues

Theoretical considerations have been ignored in the majority of studies reviewed. A few researchers examined satisfaction within the broader conceptual framework of structure, process and outcome as proposed by Donabedian (1988). For example, Tarlov et al. (1989) in their assessment of medical outcomes examined the structure of care (system, provider, and patient characteristics); the process of care (technical and interpersonal style); and outcomes (clinical end points, functional status, general well-being and satisfaction with care). Because of the multitude of factors which influence outcome, only by direct assessment of the process itself can it be determined the extent to which an observed outcome is attributable to an antecedent process of care (Donabedian, 1988).

Few researchers provide operational definitions of client/patient satisfaction. Notable exceptions include Field, 1984; La Monica, Oberst, Madea, and Wolf, 1986; Linder-Pelz, 1982; Reeder, and Chen, 1990; Tarlov et al., 1989; and E.J. White, 1988. Labels such as attitudes (Carey & Posavac, 1982; Risser, 1975), beliefs, perceptions (Ware, Davies-Avery, & Stewart, 1978), expectations (Davis & Hobbs, 1989), and intentions (Nelson & Larson, 1993) have been used to describe satisfaction. Donabedian (1988) defines patient satisfaction as "one of the desired outcomes of care, even an element of health status itself" (p. 1746).

Some investigators consider patient satisfaction as an attribute, indicator or prerequisite of quality of care, while others feel satisfaction should be viewed as a goal in and of itself (W.C. Chang, 1990). Pope (1978) suggested that patient satisfaction and perceived quality of care are two separate constructs. Indeed, Eriksen (1983) found predominately inverse relationships between quality of nursing care and patient satisfaction with nursing care. Patient satisfaction tended to be lower on units where nurses provided good physical care and taught patients health maintenance whereas patient satisfaction tended to be higher on units which oriented patients to the environment and extended courtesy to patients. Therefore, what is viewed as "good" nursing practice by nurses may not be viewed as such by patients.

The boundaries of the construct patient/client satisfaction are not clearly defined. The possibility has been suggested that satisfaction and dissatisfaction may not be on the same continuum (La Monica et al., 1986) as high ratings of patient satisfaction frequently have been accompanied by complaints. However, E.J. White's (1988) findings did not support this position. E.J. White established that wording the item in a negative or positive manner determined loading for the dissatisfaction factor rather than the content of the item. Herzberg's (1966) theory claims that satisfaction tends to be expressed in terms of feelings of personal growth, achievement and belonging, whereas dissatisfaction is expressed in terms of physical amenities and environmental factors.

In addition to the boundaries, the dimensions of client/patient satisfaction have also not been clearly identified, although it is generally accepted that it is a multidimensional construct (Hulka et al., 1975; Ware & Snyder, 1975). Ware et al. (1978) reviewed over 100 studies and defined a taxonomy of patient satisfaction to include eight characteristics: art of care, technical quality of care, accessibility/convenience, finances, physical environment, availability, continuity, and efficacy/outcomes of care. Risser (1975) identified three categories of client satisfaction with nursing care in a primary care setting: 1) the technical-professional factor, 2) the educational relationship, and 3) the trusting relationship between the nurse and client. Reeder and Chen (1990) identified the dimensions of client satisfaction with nursing care in home health care as including: availability of care, continuity of care, provider competence, personal qualities of the provider, and general satisfaction. Because of the lack of consistent definition of the construct patient/client satisfaction, a plethora of instruments to measure satisfaction have been developed.

Instruments for Measuring Client/Patient Satisfaction

Researchers have not reached the point of developing a standardized scale to measure client/patient satisfaction with care received within specific settings. The majority of researchers develop instruments specifically for their own study, but neglect to establish the psychometric properties (Bond & Thomas, 1992). Abdellah and Levine (1957) interviewed patients for the purpose of identifying satisfying and unsatisfying events with nursing care. These patient-identified events formed the base for the first satisfaction questionnaire. Although testing of the instrument was extensive, estimates of reliability and validity were not reported. Risser (1975) developed an out-patient instrument with three dimensions of patient satisfaction with nursing care: technical-professional care, trust, and patient education. This instrument was subsequently modified for inpatient use by Hinshaw and Atwood (1982), La Monica et al., (1986), and E.J. White (1988). Eriksen (1988) also developed a patient satisfaction with nursing care questionnaire which used a magnitude estimations scaling approach. The items for the questionnaire were identified from the literature and from previous satisfaction tools. Ventura, Fox, Corley, and Mercurio (1982) estimated the internal consistency of the Risser scale. The results cast doubt on the discriminant validity of its subscales. This lack of discriminatory ability in satisfaction scales is evidenced by high levels of patient satisfaction recorded in the majority of studies (Bond and Thomas, 1992).

A useable, reliable and valid standardized measure of patient satisfaction with hospitalization care was developed and named the Patient Judgments of Hospital Quality (Hays, Nelson, Rubin, Ware, & Meterko, 1990; Rubin, Ware, & Hays, 1990). The content of the instrument was based on a literature review of studies concerning patients' assessments of their inpatient experiences (Rubin, 1990) and on a taxonomy of patients' concerns (Meterko & Rubin, 1990). The taxonomy was developed from focus group discussions and verbatim comments from questionnaires. However, the questionnaire development comprised only 29 patients and there was no mention of saturation or the representativeness of the sample (Bond & Thomas, 1992). Because these instruments have been developed for patients in acute care settings, they are not appropriate for a home setting.

Schmele (1985) developed an instrument for evaluating nursing practice in a home setting, based on the nursing process. Reeder (1991) has integrated the work of Risser, Hinshaw and Atwood and of Schmele in the development of the Client Satisfaction Survey (CSS), which was designed specifically for home health. A notable finding in the development of the CSS was that the correlation between this instrument and a nurse satisfaction scale was low, suggesting that nurses and clients derive their satisfaction with nursing care from different perspectives. The scope of this questionnaire is too narrow for the purpose of this study, as more than a nursing service may be provided to clients on home care.

Alberta Health (1989a) developed a Client Outcome Tool (COT), specifically for clients on home care programs. The sample, reliability, validity and results of this study have previously been discussed. To the investigator's knowledge none of the home care programs in Alberta are presently using the COT as it required approximately two hours to administer (Marek & Lang, 1993) and provided little new information (J. Hunt & A Kohler, personal communications, April 21, 1992).

C.W. Nelson and Niederberger (1990) reviewed patient satisfaction surveys from 18 health care institutions and concluded that patient surveys may be failing to record actual levels of patient satisfaction since the instruments were often designed without broad-scale patient consultation. Some surveys focused on criteria established by professionals that may not reflect what was important to the patient. In addition, there was a considerable gap between the content of many patient satisfaction surveys and what prior research had indicated to be important determinants of satisfaction. Often insufficient attention was directed to patient satisfaction with technical competence, outcomes, continuity, and patient expectations. Weak methodologies were also considered to limit the value of many patient satisfaction surveys. Commonly encountered methodological problems with client/patient satisfaction research are presented in the following section.

Methodological Issues

Much has been written about the methodological problems with satisfaction research. One of the difficulties is that the researcher is uncertain of the participant's point of reference when responding to a question. For example, studies of those suffering from chronic conditions have shown how patients became "experts" and tend to become more critical of and less satisfied with their care (Carr-Hill, 1992). Other factors which may influence honesty or accuracy of response are: a) social desirability (French, 1981; Lebow, 1974; Nehring & Geach, 1973); b) fear of reprisals (French, 1981; Nehring & Geach, 1973; Pearson, Hocking, Mott, & Riggs, 1993; E.J. White, 1988); c) inability to discriminate between a variety of caregivers (Lebow, 1974; Moores & Thompson, 1986; Nehring & Geach, 1973); d) acquiescent response set (La Monica et al., 1986; Ventura et al., 1981; Ware, 1978; E.J. White, 1988); and e) item wording (French, 1981; Lebow, 1974; Patrick et al., 1983; Ware, 1978).

Ware (1978) demonstrated that 40 to 60% of respondents of satisfaction questionnaires manifest some degree of acquiescent response set (ARS) and from 2 to 10% demonstrate noteworthy ARS tendencies. Occurrences of ARS accounted for significant upward bias in satisfaction scores computed from favourably worded questionnaires and significant downward bias in scores computed from unfavourably worded items. These biases were greatest for groups reporting lower educational attainment or less income. La Monica et al. (1986) posits in her study that although the use of negatively worded items reduced ARS, it may have created a problem with social desirability set. Patients who are uncomfortable disagreeing with a positively worded statement may be more comfortable agreeing with a negatively worded item because the presence of such statements is acknowledgement that such things can and do happen. Thus, the negative statements may permit or sanction an honest response in a way that positive statements do not. E.J. White (1988) reported that while several participants in her study verbally communicated concerns to the investigator, only one of these respondents expressed a lack of satisfaction on the questionnaire. These high ratings were felt to be possibly influenced by implicit threat.

The timing of the measurement may also influence the response. E.J. White (1988), for example, found that new mothers' satisfaction with nursing care decreased between the time measured in hospital and at 6 weeks post-partum. French (1981) strongly suggested that the research be carried out as close to the relevant events as possible in order to reduce recall bias. Petersen (1989) posits that obtaining and using satisfaction data is an ongoing process, with care providers continually looking for opportunities to improve satisfaction.

To overcome some of the response biases French (1981) recommends interviews with participants rather than self-completion questionnaires. In addition, the different types of questions asked clearly generate different kinds of data (Carr-Hill, 1992). The results of unstructured questions are different from those obtained when direct questions are used. This discrepancy may be due to individuals reporting satisfaction or dissatisfaction when asked directly but not giving sufficient priority to these aspects to mention them spontaneously in response to open-ended questions (Locker and Dunt, 1978). As well, clients'/patients' responses may differ depending on the extent to which the interviewer is affiliated with the service (Fizpatrick, 1984). Participants are more likely to be candid if they are interviewed by an independent investigator and assured confidentiality.

Summary

This beginning literature review revealed that the majority of satisfaction research has been conducted in acute care and ambulatory care settings. Since research in this field should be context specific, the results of these studies cannot be generalized to the home setting. A paucity of satisfaction research exists in relation to services offered in the community and even less in relation to the professional and support services provided to clients on home care. The COT, specifically developed for Alberta Home Care Programs, is presently not being used by any of the Home Care offices in the province of Alberta. Perhaps this tool has not been found to be useful as clients were not involved in the development of the tool. Methodological problems such as acquiescent and social desirability response sets may also have affected the questionnaire's usefulness.

Client/patient satisfaction is a complex construct. Agreement among researchers has not been reached regarding: the definition and boundaries of the construct client/patient satisfaction; the determinants of client/patient satisfaction; or acceptance of a standardized measurement tool. Measures of satisfaction often lack conceptual soundness (Thompson, 1986), measure only certain unspecified dimensions and measure aspects considered to be important to the researcher, which may or not be viewed as equally important by the client/patient (Wrigglesworth & Williams, 1975). As there is an increasing emphasis on consumer satisfaction with the provision of health care services, and as home care is assuming a greater role in providing a continuum of care for Albertans, there is a need for a systematic exploration and advancement of knowledge in the area of client satisfaction with home care. Only when client satisfaction with home care can be accurately measured will it be considered an indispensable indicator of quality of care. Understanding the constructs client satisfaction and dissatisfaction and identifying what elderly clients perceive as being important in relation to their satisfaction and dissatisfaction with home care are the first steps in refining or developing a reliable and valid instrument to measure client satisfaction with home care.

111. METHODS

Research Design

The purpose of this study was to examine what elderly clients perceived as being important in relation to their satisfaction and/or dissatisfaction with home care. As evident from the review of the literature, what home care clients perceive to be important in determining their satisfaction has not, to date, been comprehensively and systematically investigated. A qualitative, exploratory research design was selected. The objective of this design is to uncover something that has never been examined before from the emic perspective, that is, the real experience of the situation from the informant's point of view (Brink, 1989). The utilization of an inductive approach, as compared to a deductive approach, enabled the investigator to gain a fresh perspective in an area that has been strongly influenced by professionals' view points. Included in this chapter is a discussion of the sample, data collection and analysis, issues of reliability and validity, and finally ethical considerations.

Sample

The sample for this study was a purposeful sample. Informants were selected from those clients who were 65 years of age or older, and were enrolled in one of two home care programs located in two urban-rural centres in Alberta, Canada. Additional inclusion criteria included: 1) ability to understand and speak English; 2) orientation to person, place and time; and 3) ability and willingness to reflect on their experience with home care and to verbalize their thoughts and feelings in relation to this experience. Two lists, one for each home care program, were generated from the provincial Home Care Information System. These lists indicated the home care identification numbers of those clients who were 65 years of age or older. Clerical personnel from each home care program randomly selected 50 identification numbers from each list and matched the numbers with client names. An additional 20 numbers were randomly selected as the response rate was initially inadequate. The investigator was unaware of the names of potential participants. Introductory letters (see Appendix A) and self addressed stamped postcards were mailed by the home care clerical personnel to a total of 120 clients. The purpose of the study, the procedures, what was expected of the informants, and the estimated time commitment were briefly explained to the potential participants in the introductory letter.

Those clients wishing to participate and/or wanting further information about the study were requested to telephone the researcher or return the enclosed postcard to the researcher. Clients with a variety of experiences were selected, for example, the length of time on home care, the amount and types of services received by the client, diagnosis, and apparent stability of health. The number of hospitalized days and the number of visits to their physician in the last six months were indicators of health stability. This information was obtained from the potential participants during the initial contact with the researcher. Twenty clients volunteered to participate and 12 were selected. Two participants who were interviewed were felt to be unsuitable and not included in the study as they were unable to recall their experiences with home care. The process of informant selection, interviewing, and data analyses continued until no new information was obtained and the description was rich and complete, that is, until saturation occurred. The resulting sample size was ten informants.

Data Collection

Face-to face, guided interactive interviews were the primary method of data collection. During the first interview, rapport began to be developed, an informed consent form was signed (see Appendix B) and a biographical data form was completed (see Appendix C). The researcher was open to allowing the interview to be directed by the informants' responses into areas previously unanticipated by the researcher (Field & Morse, 1985). Guided by the on-going data analysis, more probing questions (see Appendix D) and other techniques were used during the subsequent interview in order to clarify, expand and/or confirm data, interpretations and conclusions. All interviews were conducted in the privacy of the informant's own home at a time which was mutually convenient for the informant and researcher. Each interview lasted from one to two-and-a-half hours. With the informant's permission these interviews were audiotaped and subsequently transcribed verbatim. All but one informant was interviewed twice. This participant became seriously ill during the study and was physically unable to be interviewed the second time. A total of 19 interviews were conducted in this investigation.

As the participants may not have been accustomed to formulating their ideas in depth, the researcher asked them to tell a story about an actual and/or ideal experience which illustrated satisfaction and/or dissatisfaction with home care. In addition, 10 scenarios were developed which reflected experiences portraying satisfaction or dissatisfaction based on the initial interviews and on the literature (see Appendix E). An example of one of the scenarios follows:

> Mrs. C. has become very good friends with her homemaker. The homemaker seems to know exactly what Mrs. C. needs without being told and will do extra little things for Mrs. C. such as mailing her letters. Mrs. C. thinks of her homemaker as she would a family member. Personal information is often shared between them.
>
> Is this the type of relationship you have with your home care worker(s)? If not, in what ways is your relationship with your home care worker(s) different from this one? In what ways is this relationship the same as the kind of relationship you would like to have with your home care workers? In what ways is this relationship different from the kind of relationship you would like to have?

Preliminary verification that the scenarios accurately portrayed findings from analysis of the initial interviews and from the review of the literature was sought from the thesis supervisor. Face validity of the scenarios was confirmed by the thesis committee members and three home care nurse experts. The scenarios were then shared with the participants in order to validate the dimensions of satisfaction or dissatisfaction incorporated in the scenarios.

Lastly, the participants were asked to rate in importance the dimensions of satisfaction and dissatisfaction which had been identified (see Appendix F). To facilitate the process of rating the dimensions, a 4-point Likert scale was used. This scale had potential responses ranging from unimportant, represented by a 1, to very important, represented by a 4. This approach offered another means whereby the participants were asked to consider each identified dimension and to quantify its importance for them.

Field notes were used to supplement the audiotapes. The physical setting, description of the participant, impressions and non-verbal communication observed during the interview were noted immediately following each interview. Subjective biases, recognized by reflexive analysis (Krefting, 1991), thoughts, feelings, hunches and areas to be explored further in subsequent interviews were documented with the field notes. Logistics of the study were recorded in a separate diary.

Data Analysis

Data collection and analysis occurred simultaneously. A hierarchical thematic analysis was completed as described by Colaizzi (1978). The transcripts were read through and impressions of the meaning of the experiences were formulated. The key statements were then identified. These were listed in the order in which they appeared in the text, then paraphrased and themes identified. Once the themes were recorded, then they were clustered.

The next step involved putting the clusters into higher order clusters. This stage of data analysis constituted a "within person analysis". Following completion of this analysis for each informant an "across persons analysis" was completed which abstracted shared themes to form a pattern or structure of the phenomenon. Lastly, a written synthesis of the final structure captured the essence (meaning) of the phenomenon (Osborne, in press) and the development of propositional statements derived from the investigation provided a sound basis for further research.

Reliability and Validity

Agar (1986) suggested that in order to fit the qualitative view, validity and reliability should be replaced by such terms as "credibility", "accuracy of representation" and "authority of the writer". Several strategies were incorporated in this study to enhance credibility (validity), such as, prolonged engagement (Lincoln & Guba, 1985) with the informants as two face-to-face interviews were conducted. Thus, rapport increased and the informants were less likely to respond in socially desirable ways but rather were willing to share personal experiences. By spending time with the informants recurrent themes became apparent. As informants' responses may differ depending on the extent to which the interviewer is identified with the service (Fitzpatrick, 1984), the investigator emphasized that she had no affiliation with the home care agencies, thus decreasing the informants' possible fears of repercussions for negative appraisals.

Four other strategies were used to enhance credibility. First, purposeful sampling, a form of non-probability sampling was utilized as it was assumed that all clients on home care were not equally able to articulate the knowledge sought by the investigator (J.M. Morse, 1986). A variety of informants who were willing and able to share experiences which illuminated satisfaction and dissatisfaction with home care were selected. Second, triangulation of data sources and methods were utilized as each tapped a different aspect or dimension of the problem being studied (Knafl & Breitmayer, 1991). Selecting a variety of informants from two different home care programs, contributed to triangulation of data sources. Triangulation of data methods occurred as various means of data collection were used, such as, open-ended questions, scenarios, story telling, ratings, observation of nonverbal responses, field notes, and the biographic information forms. Third, member checking (Lincoln & Guba, 1985) was accomplished by continually clarifying and validating data, interpretations and conclusions to determine "goodness of fit" with informants and representativeness of the data as a whole. In addition, member checking was enhanced by having the participants validate the dimensions described in the scenarios and by rating the importance of identified dimensions of client satisfaction and dissatisfaction. Lastly, interpretations of the data were validated by the juridical process of presenting coherent and convincing arguments (Osborne, 1990).

Strategies to improve dependability (reliability) included: 1) the exact procedures and data analysis used in the study were described; 2) repeated interviews with each informant allowed the researcher to ask the same questions over again or reframe the questions to assess consistency of responses; and 3) segments of the transcript were analyzed, left for two weeks, then reanalysed and the results compared (Krefting, 1991). Finally, but most importantly the "authority of the writer" must be addressed.

In order to enhance the authority of the researcher, three strategies were employed. First, bracketing, that is, the qualitative researcher must recognize that the assumptions she or he holds may be erroneous and must subject her or his biases and predispositions to systematic inquiry in order to understand them (Johnson, 1988). This investigator attempted to articulate the assumptions she held through the process of being interviewed by a colleague prior to conducting interviews with the participants. The interview was audiotaped and transcribed so that these initial thoughts and feelings could be referred to throughout the investigation. In addition, ongoing rigorous reflection and repeated discussions with others proved to be a valuable means of exploring biases and assumptions. These were documented with the field notes and regularly reviewed.

Second, a pilot study which consisted of interviewing an elderly client on a different home care program was conducted. The purpose of the pilot study was to identify problems in the research design, to refine the data collection and analysis plan and to give the researcher experience with the informants and methodology (Lackey & Wingate, 1989). As the investigator had been a home care case coordinator for many years, switching from the role of clinician to researcher required some practice as she tended to offer advice and suggestions to the informant. Thus, the pilot interview provided the opportunity for the researcher to develop the required skills.

Lastly, following the pilot interview and all subsequent interviews, the thesis supervisor read the transcripts, field notes and data analyses and provided feedback to the researcher regarding her ability to appropriately guide the interviews, and her interpretations of the data. Discussions with the thesis supervisor and with colleagues occurred throughout the process in order to gain new insights.

Ethical Considerations

Several strategies were used to ensure the protection of human rights in this study. The researcher obtained ethical clearance from the joint committee of the Faculty of Nursing, University of Alberta and the University of Alberta Hospitals, Division of Nursing and from the two host agencies. Participation in the investigation was voluntary and informants were free to withdraw from the study at any time and to withdraw their data, by contacting the researcher and/or thesis supervisor. Both had a twenty-four hour answering machine. The participants were informed that their decision to participate or not, had no bearing on their eligibility to receive services through the home care program. A signed informed consent was obtained from each participant prior to the start of the interview (see Appendix B). Two copies of the consent form were signed, one copy was given to the informant and one retained by the researcher.

There were no apparent risks to the participants. Indeed, several participants commented that they appreciated having the opportunity to share their experiences of home care with the investigator. All participants were guaranteed confidentiality. Names of participants do not appear on any of the collected data. Only an identification number was used to differentiate the response data. A master list linking the numbers to names was kept in a locked filing cabinet, separate from the data. Also the consent forms and contact sheets were kept in this filing cabinet. The transcriber deleted or altered any names and other identifying information when transcribing the data.

At the completion of the study, the audiotapes and transcripts will be retained by the researcher for a minimum of seven years in a locked filing cabinet for possible secondary analysis. Ethical clearance will be obtained prior to secondary analysis. The signed copies of the consent forms, the master list and contact sheets will be kept for the duration of the study and for a full calendar year following its completion and then destroyed.

IV. FINDINGS

The findings are presented in this chapter. The research questions which guided this study were: 1) what do elderly clients perceive as being important in influencing their satisfaction with home care; 2) what do elderly clients perceive as being important in influencing their dissatisfaction with home care; and 3) to what extent do the constructs satisfaction and dissatisfaction appear to be similar or different? Through the process of thematic hierarchial analysis excerpts were taken from the transcribed interviews, paraphrased, and themes formulated to reflect the essence of the excerpts. These themes were then clustered into more abstract themes. Further clustering of themes into 16 higher order categories occurred (Table 1). The themes which related to dimensions of satisfaction are discussed, followed by the themes which reflected dimensions of dissatisfaction. In addition, the similarities of these themes are demonstrated, suggesting that the constructs satisfaction and dissatisfaction lie at opposite ends of several continua of multiple dimensions.

The biographic and demographic characteristics of the sample varied. Six women and 4 men, from 68 years of age to 89 years participated in the study. All were widowed except for one informant. The participant's health status

Table 1

Higher Order Clusters and the Themes Included Within Each Cluster

Clusters of Themes	Freq.
Dimensions of Satisfaction	
1. Expectations	
Expectations of home care	7
Expectations of homemakers and PCA's	8
Expectations of nurses	4
Expectations of therapists	3
2. Infrastructure of Home Care	
Services and functions received from home care	10
Characteristics of the home care program	8
3. Attributes of Formal Care Providers	
Attributes of homemakers and PCA's	9
Attributes of nurses	9
Attributes of therapists	3
4. Relationships with the Formal Providers of Care	
Relationships with homemakers and PCA's	9
Relationships with nurses	6
Relationships with therapists	2
5. Active and Nonactive Participant	
Involved in planning and decision making	9
Uninvolved in planning and decision making	9
Dimensions of Dissatisfaction	
6. Infrastructure of Home Care	5
7. Attributes of Formal Care Providers	
Attributes of homemakers and PCA's	5
Attributes of nurses	3
8. Relationships with the Formal Providers of Care	
Relationships with homemakers and PCA's	6
Relationships with nurses	2

Table 1 continued

Higher Order Clusters and the Themes Included Within Each Cluster

Clusters of Themes	Freq.
9. Uninvolved in Planning and Decision Making	1
10. Lack of Information and/or Understanding	6
11. Gaps in the Service	2
12. Suggestions for Improving the Service	1
Characteristics of the Clients	
13. Values	10
14. Goals	7
15. Perceived Limitations	9
16. Perceived Social Support	
Formal community support (other than home care)	7
Informal support	10

Note. Frequency denotes the number of participants who discussed the theme. N = 10.

Table 2
Biographical Characteristics of the Informants

Infor-mant	Age	Gender	Marital status	No. of visits to physician in last 6 months	No. of days in hospital in last 6 months	Diagnosis
1	68	M	M	6	0	Lymphoma
2	71	F	W	8	0	Frail, digestive problems
3	71	M	W	4	0	Cancer of throat
4	74	F	W	24	35	Blind, two MI's
5	69	F	W	12	60	Bone cancer, on oxygen
6	78	F	W	2	0	Pulmonary problems, hypertension
7	73	M	W	24	60	CVA, insulin dependent diabetic.
8	82	F	W	10	0	History of cancer of breast and melanoma.
9	89	M	W	1	0	Blind, poor hearing, arthritis
10	87	F	W	6	0	Arthritis MI's.

Note. MI=Myocardial infarction, CVA=Cerebral Vascular Accident.

Table 3

Demographic Characteristics of the Informants

Informant	**Place of Residence**	**No. of Months on Home Care**	**Services Received from Home Care**	**Other Services Used in the Community**
1	Apartment	96	Nursing, OT	Physician
2	Own home, apartment	28	Homemaking Nursing	Physician
3	Own home	18	Homemaking Nursing	Physician DVA
4	Apartment	48	Homemaking Nursing	Physician
5	Apartment, daughter's home	5	Homemaking PCA, PT Nursing	Physician Respiratory therapist
6	Apartment	24	Homemaking Nursing	Physician Respiratory therapist Volunteer visitor
7	Lodge	6	PCA, Nursing	Physician, PT, DVA
8	Condominium	72	Homemaking	Physician Chiropractor Meals on Wheels
9	Own home	96	PT	Physician Volunteer
10	Daughter's home	36	PCA, Nursing	Physician

Note. OT=Occupational Therapist; PCA=Personal Care Aide; PT=Physical Therapist; DVA=Department of Veterans' Affairs.

varied as did the types of services received and the length of time on the home care program (Table 2 and Table 3). The 10 participants revealed themes which described client attributes which may influence their perceptions of satisfaction and/or dissatisfaction. Lastly, the client attributes are delineated.

Dimensions of Satisfaction

The higher order themes included within the general category of 'Dimensions of Satisfaction' were: Expectations; Infrastructure of Home Care; Attributes of Formal Care Providers; Relationships with the Formal Providers of Care; and Active/Nonactive Participant. These are discussed in order.

Expectations

Expectations are defined as those events or attributes which are considered to be probable, reasonable, and/or necessary and may be different from the actual experience. What is expected of home care in general, and home care personnel such as homemakers, personal care aids (PCA's), nurses, occupational therapists and physical therapists is discussed within the general theme of 'Expectations'.

Expectations of home care. Generally, the participants expressed that their expectations in relation to home care were being met, "Actually I don't think there could be anything much better than this right here" (07). One participant felt that home care was presently meeting her needs but expressed concern that if her needs increased then home care would not be able to provide enough service:

> P: Well so long as I can do as much as I'm doing, then I'm all right...Of course I have very serious doubts about home care, if you came out of hospital. From what I'm hearing about people coming out and, I think it must be a terrible worry to be all by yourself. (06)

This same participant expected that the homemaker should only visit in the mornings as she required a rest in the afternoons (06).

There was disagreement among the participants when responding to scenario #6 (see Appendix E). Some felt that home care should provide a night sitter in an attempt to maintain the client in her own home whereas others believed that she should pay for this service or that a night sitter was not the most appropriate solution. It was also expressed that if a person is able to afford to pay for extras then the homemaker should be hired privately (04).

Expectations of homemakers and personal care aides. All but two participants received homemaking or personal care assistance (01 and 09) and most expressed that their homemakers or PCA's did more than was expected, "I think that would be very greedy of me to expect any more than what they do because I know that Sue [PCA], does more than what I even expected her to do" (10). The participants were asked to rate in importance the characteristics of homemakers and PCA's by reflecting on the ideal and not on what had been their experience with the homemakers and PCA's. A second interview was not conducted with informant 01 as he was not well enough, thus he did not have an opportunity to participate in the ratings. Having a cheerful manner and trustworthiness were the two most important attributes identified. Other characteristics which were very important to the participants included: thorough, efficient, taking direction, being sensitive to the client's needs, communicating well, being knowledgable about the client on the first visit and having the same homemaker/PCA each visit.

The characteristics which were least important to the participants included being punctual and willing to do extras, such as work beyond their scheduled time or doing tasks outside of their job description. One participant felt the homemakers should be allowed to wash the inside of her windows, but was unsure if this task fell within their job description as the participant was given conflicting information in relation to this issue. Office personnel informed her that the homemakers could wash windows but the homemakers refused (06). Another participant felt the homemakers should be able to move furniture in order to vacuum underneath (02).

There was disagreement among the participants about the importance of the homemaker/PCA being available when needed. Some participants felt that if they had an appointment at the same time as the homemaker's scheduled visit then an attempt should be made by the homemaker to switch her time, whereas others felt this would be asking too much of the homemaker as her time is already booked. It was also not expected that the homemaker/PCA have time to spend with the client or show interest in the client. It was slightly more important that the homemaker/PCA be willing to become a friend (Table 4). In addition, in response to scenario number ten, only one participant felt that the homemaker should be responsible to repay the damage she had caused to the participant's property (08).

Expectations of nurses. Seven of the ten participants had a nurse visiting them. One of these participants was a nurse herself and felt that because of this she may expect more from her nurse. Instead, she expressed that the nurse did more than was expected as she contacted the other health care professionals involved and informed them of the participant's deteriorating health rather than leaving it up to the participant to do on her

Table 4

Rating in Importance the Characteristics of Homemakers and PCA's

	Informants									
Characteristics	2	3	4	5	6	7	8	9	10	**Total**
Cheerful	4	4	4	4	4	4	4	4	4	36
Trustworthy	4	4	4	4	4	4	4	4	4	36
Sensitive to your needs	4	4	4	3	4	4	4	4	4	35
Communicates well with you	4	2	4	4	4	4	4	4	4	34
Efficient	4	4	4	2	4	4	4	4	4	34
Thorough	4	3	4	2	4	4	4	4	4	33
Consistent	4	4	4	4	4	2.5	4	1	4	31.5
Takes direction	3	2	3	3	4	4	4	4	4	31
Knows about you	4	2	4	2	4	4	4	2.5	4	30.5
Will be a friend	4	4	1	4	2	4	2.5	4	4	29.5
Interested in you	4	4	1	3	4	4	2.5	1	4	27.5
Has time for you	4	2	1	4	1	4	2.5	4	4	26.5
Available	3	2	1	4	4	4	4	2	2	26
Does extras	3	2	2	3	2.5	4	4	2	2	24.5
Punctual	4	2	1	2	2.5	4	4	1	4	24.5

Note. 1=unimportant; 2=slightly important; 3=moderately important; and 4=highly important. Maximum score=36.

own (02). But not all of the participant's expectations were met. One participant felt that a particular nurse did not meet her expectations as she did not visit frequently enough to monitor her blood pressure, left the responsibility of obtaining a flu prescription up to the participant and did not visit to administer the flu injection as quickly as the participant felt she should have. If this participant became very ill she felt her expectations of the nurse would increase (06).

By asking the participants to rate in importance the ideal characteristics of nurses, the most important attributes identified were a cheerful manner and that she listens to the clients. Also rated as highly important were the following characteristics: the nurse appears interested in the client; is knowledgable about nursing; communicates well with the client; provides good nursing care; answers questions; and provides valuable information. Slightly less important but still rated very highly were: appears to communicate with other staff; trustworthy; shares information and is sensitive to the needs of the client. Overall, willingness to do extras was rated as the least important characteristic, with willingness to become a friend also rated low as there was disagreement among the participants regarding the importance of this particular attribute (Table 5).

Table 5

Rating in Importance the Characteristics of Nurses

	Informants							
Characteristics	2	3	4	5	6	7	10	**Total**
Listens to you	4	4	4	4	4	4	4	28
Cheerful	4	4	4	4	4	4	4	28
Interested in you	4	4	4	3	4	4	4	27
Communicates well with you	4	4	4	3	4	4	4	27
Knowledgable	4	4	4	3	4	4	4	27
Provides good care	4	4	4	3	4	4	4	27
Answers questions	4	4	4	3	4	4	4	27
Provides information	4	4	4	3	4	4	4	27
Sensitive to your needs	4	4	4	2	4	4	4	26
Trustworthy	4	4	1	4	4	4	4	25
Shares information	4	4	4	1	4	4	4	25
Communicates with other staff	4	4	1	4	4	4	4	25
Has time for you	4	4	4	2	1.5	4	4	23.5
Available	4	2	4	3	4	4	2	23
Involves you in planning	4	2	3.5	3	4	4	2	22.5
Punctual	3	4	1	2	4	4	4	22
Consistent	4	4	1	4	1.5	2.5	4	21
Willing to be a friend	4	2	1	2	1.5	4	4	18.5
Cheerful	4	2	1	2	1.5	4	2	16.5

Note. 1=unimportant; 2=slightly important; 3=moderately important; and 4=highly important. Maximum score=28.

__Expectations of therapists__. Only three of the participants had contact with a therapist. One participant had received weekly physical therapist visits for approximately eight years during which an exercise program was conducted, another had received a few visits by a physical therapist to assess her for mobility equipment and to set up an exercise program. The third participant had had an occupational therapist visit on a few occasions in relation to assessing and obtaining appropriate eating utensils and bath aids. No information was expressed spontaneously during the interviews in relation to their expectations of the therapists. When asked to rate in importance the ideal characteristics of therapists, one informant rated all of the characteristics as highly important (07). Another rated them all as highly important except for the characteristics of listening well to the client and having time to spend with the client. These were rated as slightly important (09). The third informant rated all of the characteristics as highly or moderately important except for the characteristic of willing to share information about the client’s health status (see Table 6). This participant had had an unfortunate experience during which the nurse told her information she did not want to hear and thus rated this characteristic as unimportant (08).

Table 6

Rating in Importance the Characteristics of Therapists

	Informants			
Characteristics	5	7	9	**Score**
Interested in you	4	4	4	12
Cheerful	4	4	4	12
Knowledgable	4	4	4	12
Communicates well with you	4	4	4	12
Provides good therapy	4	4	4	12
Provides information	4	4	4	12
Trustworthy	4	4	4	12
Does extras	4	4	4	12
Involves you in planning	3	4	4	11
Consistent	3	4	4	11
Willing to be a friend	3	4	4	11
Sensitive to your needs	3	4	4	11
Available	3	4	4	11
Punctual	3	4	4	11
Answers your questions	3	4	4	11
Listens to you	4	4	2	10
Shares information	1	4	4	9
Has time for you	3	4	2	9

Note. 1=unimportant; 2=slightly important; 3=moderately important; and 4=highly important. Maximum score=12.

Infrastructure of Home Care

Within the general theme of 'Infrastructure of Home Care', the services and functions which were received by the participants are explicated. The services included homemaking, personal care assistance, nursing, occupational therapy, and physical therapy. Functions are defined as those roles, acts or tasks performed by the home care workers. In addition, the positive characteristics of the home care program as perceived by the informants are described. The negative characteristics of home care are discussed within the category of 'Dimensions of Dissatisfaction'.

Services and functions received from home care. Homemaking and/or personal care assistance were/was received by all but two participants. The frequency of the service ranged from four hours daily to three hours biweekly. The functions performed by the homemakers included heavy homemaking tasks such as vacuuming, washing floors, and cleaning the bathroom, stove and fridge. Homemakers would also grocery shop or assist with meal preparation if this was needed. Companionship was also an expressed function of the homemakers. PCA's assisted with the participant's bath, changed the bed linen and put the towels and bed linen in the wash.

The nursing visits ranged from daily to an occasional (possibly yearly) reassessment visit. A wide variety of roles and functions were carried out by the nurses. These functions included: daily visits to check if the client needed anything; filling weekly medication dosettes; preloading insulin syringes every three to four days; teaching a spouse to do catheter changes and dressing changes; monitoring blood pressure, vital signs, blood sugars and pain; foot care; treating bed sores; making referrals to other disciplines within home care; communicating with other health care professionals involved with the client; ordering equipment, dressings and insulin supplies; offering advice regarding the need for medical follow up; coordinating the type and amount of services; and assessing the client for a Friendly Visitor.

As indicated above, physical therapists provided exercise programs, and assessed for and ordered mobility aids. The occupational therapist arranged for bath aids and aids for eating.

Characteristics of the home care program. Home care services in some cases were set up prior to the participant's discharge from hospital and were initiated as soon as she/he arrived home. For the other informants a referral had been made by a family member, physician or by the participant. The response rate to this referral was felt to be very quick, "they were out that week...they were very good that way" (10). Most participants reported that their home care worker had been consistent, that is, the same individual had been visiting for some time. If there was a change in homemakers, the participants appeared to understand the reason for this. For example, an informant explained that two of her homemakers had been switched, as one experienced homemaker was needed by a more seriously ill client and the other homemaker's temperament was not compatible with the participant (06). If homemaking and a PCA were both required by the participant then this service was provided by the same individual.

The homemakers were felt to be specially trained as "they can cut toe nails and they do most things that you need doing" (04). In addition, they appeared to know about the participants on their first visit. Thus, even though the participants could not conceptualize beyond their own personal experience with their home care workers, aspects of the organizational structure which influenced them were apparent.

Attributes of Formal Providers of Care

The formal providers of care include the homemakers, PCA's, nurses, physical therapists and occupational therapists. In this section the positive attributes of the formal providers of care as perceived and experienced by the participants are delineated. The negative attributes of the formal providers of care are discussed within the category of 'Dimensions of Dissatisfaction'. Attributes are defined as the distinguishing traits or qualities of the providers of care.

Attributes of the homemakers and personal care aides. Some of the positive characteristics attributed to the homemakers and PCA's included the following: does extras, thorough, efficient, takes direction, appeared interested in the participant and attempted to "please her", sensitive to the participant's needs, trustworthy, knowledgable about their work, required little direction after two or three visits, "nice people", trained, dedicated, friendly, pleasant, careful with the furniture, flexible, spent time with the participant, allowed participant to be independent and yet safe and communicated well with the informant. Some of the extras which the homemakers were willing to do on their own time consisted of grocery shopping, running errands, mailing a letter, taking ironing home, laying a cement sidewalk, and making plastic covers for the participant's lawn chairs. Extras also included those activities not in their job description, for example, "I had her at one time digging some potatoes for me" (09). In addition they included activities in response to being sensitive to the participant's needs:

> P: And she comes in...like yesterday morning...after my bath, she helped me get dressed to go to the doctor. She combed my wig for me and you know...Just extra little things that the other girls don't think about, you know. Oh, she's wonderful. (05)

The trust which one participant felt for his homemaker was demonstrated by:

> P: She has a key to the house, the back door. And if I'm out she'll come in and just carry on. So what I mean is...there's a lot, there's a hell of a lot of trust there to begin with. And I would say that some of my friends, I wouldn't trust them as far as I would with young Nancy. (03)

This same participant felt that his homemaker gave him "more attention than even [his] own family" (03).

Attributes of the nurses. As one participant explained in reference to her nurses, "they're all good, they're really very nice people" (04). The positive attributes of the nurses included: willing to do extras; caring; kind; concerned; understanding; friendly; sensitive to the participant's needs; knowledgable; available when needed; communicates well with the participant, other home care personnel and health care professionals; has time for the participant; trustworthy; provides good nursing care; provides valuable information; is "like a counsellor"; and involves participant in the planning of his/her care. Specific actions performed by the nurses which were appreciated by the participants were: responded quickly to requests for assistance (03 and 10); identified and arranged for increased services (05); offered direction and encouragement (01); contacted other health care professionals when necessary (01 and 02); phoned if she was going to be late and prior to visiting (10 and 06); and dropped in daily to ask if the participant needed anything (07) or occasionally for a "friendly visit" (03). The extras which the nurses did on their own time involved driving a participant to visit her son in a neighbouring village (04) and making some Christmas decorations for a participant (01).

Attributes of the therapists. One participant described his physical therapist as a "mother" as she appeared concerned about him, "she likes to see that I get decent treatment" (09). This therapist initiated the homemaking service when the participant's live-in-nanny was no longer available. She also encouraged the participant to see his physician when necessary. Other characteristics attributed to the therapists included: friendly, kind, "tries to help", punctual, willing to share valuable information, trustworthy and willing to do extras.

Relationships with the Formal Providers of Care

Following is a description of the positive relationships or associations which the participants had with their formal providers of care. The formal providers of care included homemakers, PCA's, nurses, and therapists. A description of the positive relationships with each of these groups of providers follows, the negative aspects of the relationships are described within the category of 'Dimensions of Dissatisfaction'.

Relationships with the homemakers and personal care aides. The three informants who had PCA's visiting, all described the PCA as a "friend". Because of the intimacy of the bath experience it was important to the participants that they were comfortable with the PCA. One participant had several homemakers but allowed only one to assist her with her bath, "I'd like a little dignity left...and she's sort of like my own" (05). Having a consistent PCA was very important to another participant:

> P: You know yourself you get a little shy with strangers coming in to wash your body and that. And you feel better...you feel a little freer with the other [regular PCA]. (10)

Within this context it appeared the participants developed close relationships with their PCA's, as information regarding the PCA's family and her activities outside of work were known to the participant. Even the male informant felt he knew his PCA well as she shared stories about the other residents with him (07).

The reciprocal nature of the relationships with the PCA's was apparent by the comment, "I generally try and let her go cause she's got...She does quite a few here every day" (07) and by the following description:

> P: She [PCA] understands my situation and she does her best to do what she is able to do for me. And she knows too that I don't expect her to do something that is not right to ask her to do. Like I wouldn't go and ask her to clean up the kitchen or something like that, never. (10)

The relationships with the homemakers were also reciprocal:

> P: But if she does it [extras], it's more friendly cause you can make it up [in] other ways to some of them...I've had others that like to have a cup of coffee and a cookie or something in the mornings. (06)

The participants were asked about exchanging gifts with their homemaker or PCA as one participant had indicated that by accepting a gift from her homemaker she no longer felt comfortable in giving directions to her:

> P: She [homemaker] went out and bought me a bottle of Irish Cream. After that, I felt I couldn't say nothing to her about...she wasn't doing something the way I wanted it because I'd received a gift. And it just got to a point that I had to say to Kathy [homemaker's supervisor] at the finish, that I had accepted a gift and it wasn't...I felt guilty so they changed over. (02)

The other participants either had not exchanged gifts with their homemakers or if gifts had been exchanged they "were accepted in the way it's offered" (06) and considered to be a "lovely gesture" (04). These participants did not feel the act of exchanging gifts had affected their relationships, if anything "it made us a little closer" (05).

Generally the relationships developed with the homemakers were not as personal as with the PCA's. For one informant the homemaker's willingness to become a friend was most important as "if I'm alone you know, I could talk to her for awhile, cause I can't get out much and visit very much" (09). This participant lived alone and had difficulty going outdoors due to poor vision. The companionship provided by the homemaker was greatly appreciated. For other participants who had a larger social network the desire for companionship from the homemaker was not as important:

> P: I don't wish a relationship to...to say that I'm her friend. Because then it becomes...my friend is coming to clean my house. No, I don't feel I would like an outside relationship. I mean if I met her on the street, I'd talk to her. But that's as far...(04)

The relationships with the homemakers were often seen as business-like, as the homemaker was expected to work and only "stop and talk for a minute of two" (02). One participant regretted wasting the homemaker's time by talking with her for a half an hour before she began her work. When the participant was asked if she would like more time with the homemaker her response was "only if I didn't have to pay for it" (08). Personal information was not shared between the participant and the homemaker, only information "which is fine too for anyone to know" (08).

One participant summarized the relationship she had with her homemaker by "she should be treated as a person...there are lots of things you can talk about without being that intimate" (08).

Another participant felt it did "not matter really" if the homemaker was willing to become her friend but she felt very "lucky" that she had developed a personal friendship with a previous homemaker. This homemaker had become like a "daughter" to her, as she appeared to be "not just humouring someone" but enjoyed the time spent together with the participant (06).

The need to have control over what the homemakers did seemed to vary among the participants. If the participant was having difficulty adjusting to the restrictions of the disease process or not managing well in other areas then the issue of control was more apparent. Whereas, if the participant had come to terms with her/his disease process and other areas had taken on a priority such as enjoying life to the fullest, then there was not the apparent need to have control over what the homemaker did that day:

> P: They know what's what. I'm not doing it myself. I probably might do something different...do it differently but I do it differently than Diane [daughter]. I have my own way and if I'm not up there, doing it myself, I've got nothing to say how they do it.
>
> I: Right. So do you feel that you've lost some control?

> P: No. No, I don't feel like that at all! No, not at all. (05)

The kind of relationship which the participants developed with the providers of care appeared to be related to the frequency of contact, the type of task performed, the personalities of the homemaker and participant and the social needs of the informant. For example, a more personal relationship seemed to develop between the PCA's and participants as the task of assisting with bathing was more intimate. Usually the relationship between the homemakers and participants was more business-like. If a personal relationship developed, this was considered an added bonus. The positive relationships developed with nurses are discussed in the following section.

Relationships with the nurses. The relationships with the nurses, although often described as a "friend" were not as personal as was apparent with the PCA's. One participant referred to the nurse as a "casual friend" (03). This was probably related to the less frequent and intimate contact between the nurses and participants. One informant appeared to clarify and refine her thinking about her relationship with the nurses as the interviews progressed. She initially described her nurse as a "friend" but later clarified this by saying it was more like a "friendly visit":

> P: I don't believe in making friend friends. I'm...if I have a friend, it's a friend. But, these are people who come to the house that I'm very pleased to see, but I couldn't care if I don't see them until they come again. So, that's not a friendship, is it? I like to be pleasant to anybody that comes, you know. (04)

This participant had a new nurse by the second interview and the closeness expressed in the first interview was not apparent in the later interview. Another participant also saw his nurse as a friendly visitor:

> P: That means a hell of a lot! When you're frustrated and sitting in the house in the cold weather to have someone like yourself or Joy [nurse] to drop in for a visit. I think it's great! Very important! (03)

During the first interview with this participant it became apparent that the participant was not sure if Joy was a nurse, "I think she's a nurse" (03). Perhaps a volunteer friendly visitor would have been a more appropriate person to be visiting this participant.

The nurse's professional image did not seem to interfere with the development of a relationship with the participants as one informant explained, "It's not like nurse and patient" (02), as common interests outside of nursing, such as knitting, were shared between them. Suggestions made by the nurse were appreciated but "never a dictation" (03). As well, visiting the participants in their own homes appeared to enhance the opportunity for a relationship to develop:

> P: ...like sometimes I go to the doctor and I feel like I'm whining to the doctor. But I don't feel like that when I'm talking to the nurse. I feel I can talk to her. And, you see, she sees more than the doctor does because she comes and sees me as I am in my home. (04)

Relationships with the therapists. Only one participant knew his therapist well enough to comment on the relationship with her. This participant described the therapist as "like a mother" as she was "good" to him and "likes to see that I get a decent treatment". In return he teases her and occasionally gives her a cup of coffee. Gifts have not been exchanged between them but the informant feels this would result in a "closer" relationship. The therapist has been visiting the participant weekly for eight to ten years and recently the participant made the comment to her "I guess you can't get rid of me. You'll have to quit". "Oh", she said, "I don't mind, I don't mind coming here" (09). Perhaps, the participant is questioning his need for weekly visits in light of the present climate of fiscal restraints and health care reform.

Active and Nonactive Participant

Active participant is defined as being engaged in the action or involved in the planning and/or decision making process. Whereas, nonactive participant is defined as lack of involvement in the action, planning or decision making process. Within this general theme, 'Involved with Planning/Decision Making' is first discussed, followed by 'Uninvolved in Planning/Decision Making'. For one participant her uninvolvement in the planning of her care had a negative impact, this experience is described within the category of 'Dimensions of Dissatisfaction'.

Involved with planning and decision making. Some of the participants took a very active role in determining the type and amount of services received from home care. When first becoming involved with home care one participant claimed she was asked, "Was there anything special I needed?" (04) and another was asked what she would need when moving in with her daughter (05). Other participants initiated a change in their services. One participant decided that she would try for a month to manage without the homemaking assistance since moving from a house to an apartment. Her rationale being that "two hours [of homemaking] could be given to someone else that needs it more than what I do now" (02). This same participant had also initiated a previous decrease in service as the daily homemaker who was coming in to prepare a meal for her was not working out:

> P: We cut out the meals because I...I would walk through here after she had made a meal, and then go to the bathroom and throw up. And so we decided well, that was a waste of money because she was here for an hour, and it was at a time when I, everything that I tried to

> put in my stomach, it would just come back again. So, we decided we would, I would manage and just make a meal when I...cause I was eating every two hours so, it wasn't as if I was not getting anything at all. (02)

Another participant had requested increased hours for his homemaker as "she had to go to beat the band" (03). Home care was most cooperative in responding to his request.

Some participants were also involved in deciding the type of homemaker they preferred to have visit them. For instance, one participant who was not pleased with a homemaker because she was not willing to take direction, contacted the homemaker's supervisor. She visited and the problem was resolved by switching homemakers. Her present homemaker is preferred as, "The first thing she says is, "Now, what do you want done most today?"...I feel it's my home" (06). For this participant it was very important that she have control over her home. For another informant having control over what the homemakers did in her home was not a concern. The important issue for this participant was her bath. Although several homemakers regularly visited her, she only allowed a special homemaker/PCA to assist her with the bath (05).

A couple of participants preferred to "work with" their homemakers deciding what chores needed to be done and the order in which they were to be done (08). One participant had put off hiring help as "the way my health was I never had him because I want to be around to see what he's doing" (08).

Other areas in which the participants were actively involved included: deciding how long it was appropriate to remain alone; choosing between surgery and radiation treatment; purchasing bath aids and railings; and the planning and development of her apartment complex.

Uninvolved with planning and decision making. Most of the participants could not recall how they had become involved with home care, some thought that perhaps a family member or their physician had referred them. Three participants were too ill at the time of discharge from hospital to be involved with planning their home care services:

> P: ...because I didn't know what I would need. It was...I came home a basket case...I had no memory for one thing. I couldn't remember what happened two minutes ago. And I just wanted to lay in bed and be left alone. (05)

* * * * *

> P: They saw, they talked to the nurses at the hospitalThey talked to the doctor there and realized how serious the condition I was in and what I was going to need. So the day I came out of the hospital, they'd made all the arrangements and everything was in place...It took my concerns and my worry about what was going to happen away from me and somebody else. You know, after nursing a sick husband for 14 years and having to do everything for him and then 10 years on my own, and having to do everything for myself, it was nice for somebody else to step in and say,

> "Ok, we are going to do this". You know, I didn't have to make the decisions. (02)

This participant felt that even though she was now feeling stronger she would prefer not to be involved in deciding whether the nurse should continue visiting as:

> P: I think we'll leave it with them. Because, you know,Joyce [nurse] has had the experience, Kathy [homemaker] knows exactly what has gone on in the past. Whatever decisions they make, I would...I've got to the stage I'm very very passive. (02)

Other participants also seemed to accept the lack of involvement in deciding when and if the home care worker would be visiting:

> P: Well, I only need her once a week. She put that on herself. So, I don't know, that's alright if she comes. (09)

One participant did not expect to be involved in the planning of her care because she lived with her daughter and in fact "when she [nurse] came and talked to Rita [daughter] about it, she more or less got it all figured out" (10). The general lack of desire to be involved in those decisions which affected them may be related to a lack of energy and poor health but it may also be a reflection that this population has been given limited opportunity in the past to participate in these decisions, especially in acute care settings where a paternalistic approach has prevailed. The negative aspects of some of these identified themes are discussed in the following section.

Dimensions of Dissatisfaction

Dissatisfaction is defined as those perceptions about home care services and providers which have been presented as negative. The negative aspects of the following themes are presented: Infrastructure of Home Care; Attributes of the Formal Providers of Care; Relationships with the Formal Providers of Care; Uninvolved with Planning and Decision Making; Lack of Information and/or Understanding; Gaps in Service; and Suggestions for Improving the Service. These are discussed in order.

Infrastructure of Home Care

Dissatisfaction was revealed in relation to the infrastructure of home care. One concern was the little time available for the homemakers to complete the necessary work, "I think if Kitty had a little more time she wouldn't be nicking the things. I think she does it so quickly to get done" (08). Only the essentials were able to be completed in the allotted time, "You must choose the things that have to be done" (06). One participant had corrected a similar situation:

> P: But, she [homemaker] had to go to beat the band so I just got a hold of them over there and I asked if they would in fact allow her another hour, two hours or whatever the case may be...And there was absolutely no problem. (03)

Another complaint was the little time available to orientate new homemakers to the participant's home. Some participants felt that having a replacement homemaker when their regular homemaker was off duty for one or two visits was often not worth the trouble, "it's a nuisance" (08), as much energy was exerted in orienting the new person to their home. When a replacement worker was accepted and she did not complete all of the tasks usually carried out by the regular homemaker/PCA, the participants appeared to accept this knowing that their regular worker would soon be returning:

> P: The difference was I had a bit of a shower. She [replacement] didn't look after any of the washing. She didn't strip my bed or nothing. She didn't do my hair. So, it was just a little quick wash, more or less. And I thought my goodness, there's a lot missing in between here and...yes.
>
> I: Did you ask her to strip the bed or...did you give her any direction in what...
>
> P: No, I didn't ask her because she had only been twice and in that time well, Rita [daughter] looked after the bed. (08)

This example illustrates the need for improved communication between the regular homemaker/PCA and her replacement.

In addition, switching the homemaker's scheduled time was something one participant "couldn't cope with":

> P: She would have liked to switch me from anywhere from 7:30 to 9:00. And at 10:00 o'clock I'd get a call, "Well I won't be there until 11:00." And this...this isn't good to get up in the morning and rush to get

> washed and dressed and then to have this happening to you. And so, when that happened the last time, I said "Just forget it this week". (06)

The role of the homemaker was not always clear as the tasks the homemakers were willing to perform varied and occasionally conflicted with agency policy:

> P: It varies with the person. It certainly does. Windows are something that they will tell you they can't clean but the office will say they can do it as long as they don't take them out of the frame. (06)

Generally, participants felt that their homemakers and nurses were available when they were needed. Yet, the participants often did not know their case coordinator's name unless she was visiting regularly to provide nursing care. If services were cut back by the case coordinator there was not a clear understanding of the reason for this:

> P: They told me because of finances. This is what they told me. Maybe they thought I didn't need it, you know. (08)

Overall, clients' dissatisfaction pertained to inadequate amounts of service provided, inconsistencies in the type of service offered, lack of communication between the workers and not knowing who to contact regarding the service delivery.

Attributes of the Formal Care Providers

Some of the participants identified areas of dissatisfaction with their formal providers of care, the remaining informants felt "I cannot say anything... detrimental of any kind about them...I really mean it. They've been excellent!" (04). The negative perceptions are discussed under the same themes as found within the category of 'Dimensions of Satisfaction', namely 'Attributes of the Homemakers and Personal Care Aids' and 'Attributes of the Nurses'.

Attributes of the homemakers and personal care aides. Two participants claimed that homemakers had stolen from them. In one situation the informant's stolen jewelry was returned, as she found it under her bed (08). However, the other informant did not retrieve his stolen property as the homemaker denied taking a vacuum head and items of food. Having confronted the homemaker and informed the home care therapist about his suspicions, the participant found it easier to terminate the services of the homemaker rather than pursuing it further:

> P: What else could I do? It wasn't...you can't sue somebody if you don't know if whether it's right or wrong. And anyway, it wasn't enough money to go and sue anybody. For that kind of money, you know, you'd have to get a lawyer and it costs you way more than what it's worth. Might as well let her have it and be done with it. (09)

Another complaint from one participant was that the homemakers had caused a lot of damage to her property. She claimed that the homemaker had broken the cord on her drapes, ruined the seal on her freezer door, broken a leg off the coffee table, taken nicks out of a cedar chest and corners of the walls, and discoloured her slip. Instead of expressing her concerns to the homemaker, this participant felt "if you want somebody, I guess you have to put up with these things so forget it. So that's what I've done" (08). Instead, the participant took over doing the vacuuming around her cedar chest and no longer allowed the homemaker to do her laundry. For this participant finances were a concern and she was beginning to realize that she was no longer able to manage her condominium. All of the other participants felt their homemakers were careful with their property and had no complaints about damage done. If there was something which the homemaker was doing which disturbed the participant such as "washing my antique furniture" then the informant "got her out of doing that" (06) and the problem was resolved.

It was apparent to the participants which homemakers were working only for the income and which were sincerely interested in the participant, "you wouldn't get the two hours up and away she would go", whereas, other homemakers were willing to "go the extra mile" (06). One participant's rationale for this apparent difference in homemakers was their financial need:

> P:...obviously she [homemaker] doesn't need to [work]...That's a big difference, too. The need you know. The one I found hard to handle before...she was doing 4 or 5 houses in a

> day. Now that's an awful lot, to go home to a big family at home. [Whereas] Joyce had no where else to go, sometimes when she was here so she'd just stay for lunch and that sort of thing. (06)

Additional complaints expressed about the homemakers included: spending too much time talking; requiring a lot of direction; unwilling to take direction; not thorough enough; insensitive to the participant's needs, for example, preparing meals which the client could not tolerate (02); and showing no initiative. As one dissatisfied participant explained, "I like these people but I don't like what they do to me" (08).

Attributes of the nurses. Two of the participants had negative experiences with nurses. One nurse visited in the spring and then again in the fall to monitor the participant's blood pressure, "I...was wondering well how does she know when your blood pressure is up or down cause...mine was high you see and they were following it up". This participant understood that the nurse communicated her blood pressure readings to her physician and was surprised to discover that this was not done, "that was not good nursing". It was also felt that this nurse should have been more cooperative in obtaining a prescription for a flu injection and more prompt in administering it. For this nurse "it was very much a job to her", she appeared in a hurry and was unwilling to have the participant call her at home. The nurse would phone to say she would visit at 11:30 and arrive at 12:00. This informant had heard that "most people are dissatisfied with what was done" by the nurses (06).

Another participant had the experience of a nurse telling her things she did not want to hear:

> P: Starting with the flu. Oh, I was...I felt so rocky and the nurse insisted that I should go to the hospital. And I said, "Absolutely not!" She wanted me to go to the 'R' Hospital. But I wouldn't go over there if I had one leg, I just would not go. She was kinda put off with me. And then she started explaining, "Well, you've got this and you've got that". Well for days I was so depressed. I don't want to know about it. I know about it but I don't want to hear about it. (05)

* * * * *

> P: There's one nurse, she kept on saying, "Oh, you should see the palliative care unit they have in 'R', it's gorgeous!" Lord! That's the last thing I want to hear about too! (05)

This nurse did not appear sensitive to the participant's wants or needs. Rather she appeared to be acting out of concern and feeling responsible for the participant, attempting to convince her to respond as the nurse perceived she should. How this experience affected the participant's relationship with the nurse is discussed under a following theme entitled, 'Relationships With the Nurses'.

In the hospital setting one participant had experienced nurses telling her things which are "completely different to what the doctors told you, you know that's bad" (06). This example illustrates the importance of developing a mutually agreed upon plan of care and identifying the role of each professional and of the patient in achieving the goals of care.

Relationships with the Formal Providers of Care

Included within this theme are the negative aspects of the relationships with homemakers/PCA's and nurses. Each group of formal providers of care is discussed separately.

Relationships with the homemakers/PCA's. A couple of participants found that their homemakers were unwilling to take direction, "She was not about to do anything she didn't want to do", such as clean out the oven (06). Even if the homemaker did a thorough job but was not doing what the participant felt should be done then the participant expressed dissatisfaction, "She [homemaker] had her own ideas about what should be done, perfectly good but not what I..." (06).

One participant felt she had imposed on her homemaker but then realized that it was the homemaker who was making her feel this way as she was refusing to do whatever was asked of her (06). Another informant initially felt uncomfortable about asking her homemaker to bake a cake (05). Perhaps a clearer understanding of the role of the homemakers would have prevented these feelings. The remaining participants did not feel they had imposed on their homemakers, as one informant stated, "I never thought that way. I never had one that good" (09).

If the homemaker did something which displeased the participant, most of the participants would not hesitate to inform the homemaker and correct the situation. If this approach did not work then the informant would contact home care and "they'll change the person or speak to them" (06). One participant appeared very reluctant to share her concerns about damage done to her furniture as she was afraid of "offending her [homemaker]". On one occasion she had confronted the homemaker about a broken coffee table leg but when the homemaker denied knowing anything about it, the participant saw no value in bringing other concerns forward. Instead this participant chose to do the tasks herself (08).

Relationships with the nurses. The reciprocal nature of the relationship with the nurse was apparent. If the nurse did not appear willing to do extras when the participant had made an effort to please the nurse then the participant was disappointed:

> P: She used to come and sit down, the nurse, and I'd always have some cookies for her to take back to the office. I'd bake cookies and...I asked her one day if she would mind mailing a letter for me cause I always had the stamps. And she said, "I guess I could".

> And it was such a strange answer cause she walked by the house every day with her dog. The mailbox is at the end. I never asked again. That was strange. (06)

As previously described, the nurse who was not sensitive to the participant's wants and needs and gave the participant information she did not want to hear, jeopardized the relationship. This informant no longer enjoyed the nurse's visits and wished she would only come when called. Even though the participant feels she has expressed this desire to the nurse, she continued to visit weekly:

> P: You really don't have to come so often. I could...you know, if I need you, I'll call you. But, that's...they have their routine, I understand that. (05)

This example exemplifies the importance of exploring with the client her feelings, expectations and knowledge level instead of imposing the professional's beliefs onto the client. When this is not done the relationship suffers.

Uninvolved with Planning and Decision Making

Only one participant expressed regret at not being more involved in planning her care, "Nobody asked me how I felt when I got home...nobody had any sympathy for me at all" (08). This same participant would have liked to move to Saskatchewan but her daughter did not agree. It appeared the daughter's decision was final:

> P: And they [grandchildren] wanted me to come too. And then my daughter backed out on it

> and she...and I couldn't figure out why. And she said, "Well we're likely to move again". And then she thought well I'd be left again. And I thought, I couldn't care less if I got left. The other two grandchildren are there. And I get left here anyway. (08)

This informant appeared to want to participate in those decisions which affected her and to have more control over her future. However, she seemed to be unable to plan her future without assistance as managing her home and attempting to maintain her health took all of her time and energy.

Lack of Information and/or Understanding

Participants' desired uninvolvement with the planning of their care may have been a reflection of their lack of knowledge of home care. For example, they were unclear about the roles of home care workers, "I don't know exactly what their [homemakers'] job description is" (05). When asked what the nurse did when she visited, a participant replied:

> P: Nothing. Not a heck of a lot. There wasn't much to do. Give her a cup of coffee. (01)

In one situation where a family member had been delegated to look after filling the participant's pill dosette and ordering her medications, the participant wondered "if the home care girls would want to be bothered with something like that" (05). Indeed, this family was feeling very stressed with the amount of care required by the participant and the nurse could have taken over this task.

In addition, there was a lack of awareness of the knowledge level and skills of the health care providers as illustrated by the varied response to scenario #7 (see Appendix E). Some participants felt that it would be necessary for the lady who had had a recent heart attack to be seen by both the physician and nurse weekly, while others felt that having the nurse check her blood pressure weekly would be adequate:

> P: Well, I think that, under the circumstances I'd say she needs to see the doctor once a week. Probably the nurse advises her what she should do. But I think the nurse would advise her to see the doctor. (07)

* * * * *

> P: I think the nurse should know if she needed anything more. I think the nurse would...would... let her know if she should go to the doctor more often. That the nurse should know, well because she'll do the reading right and maybe she communicates with the doctor and therefore she should be alright. (10)

Participants were also unaware of the amount of service which could be provided:

> P: I don't know how long they stay or that... I have to find out that so I don't know. I know they speak of going to homes where the nurse drops in and does dressings and things. But, they don't indicate that they stay at all. I don't know. (06)

There was a varied response to scenario #6 (see Appendix E) as some participants felt home care should provide a night sitter in an attempt to prevent institutionalization, "it would be nice. Cause if you take everything away, there's not much point in going on" (05), whereas others felt the lady should hire a night sitter privately or suggested other possible solutions. None of the participants in responding to this scenario appeared to be aware of the criteria used to determine the amounts and types of services provided by home care.

One participant expressed that "I don't even know who the supervisor is" (08) and thus was unable to pass on her concerns about the homemaker. A couple of informants did not know their case coordinator's name as she was not actively involved with the participant. As well, there was not always a clear understanding of the reason for certain decisions, "They wouldn't give me one [a power wheelchair]. Why...I don't know. They just wouldn't that's all" (01)

Participants also expressed a lack of knowledge in relation to available community resources, such as the handi-bus service (06) and where to seek appropriate help, "I don't know how to handle this place and I don't know what to do about it" (08). There was a lack of understanding regarding their heath status; diagnosis, "It was cancer. And I gathered it wasn't a very good kind. They never did tell me. I never asked" (08); and medications as one participant's physician stated "There's so many side effects, I don't want to tell you" resulting in the participant feeling that "I just know that I just have side effects from this blinking heart thing" (08). Thus, informing clients of the roles of the home care workers, the criteria used in determining the amount and types of service provided, and supplying clients with the means of accessing the appropriate individuals when needed, may have decreased some of the areas of dissatisfaction. In addition, the identified gaps in the service were occasionally related to a lack of awareness that the service was available.

Gaps in the service

Gaps in home care service were identified by two participants. One informant expressed the concern that home care is not able to provide enough service to those who are very ill and/or recently discharged from hospital:

> P: I'm not one hundred percent keen on some of this home care, I don't know...like when a person goes out of hospital, I don't know how they manage for twenty-four hours with a visit once a day. What happens all in between? The loneliness, the fear. (06)

Having more information about home care may have relieved some of these concerns. Another participant wished that "they [homemakers] would be allowed to move pieces of furniture". Instead the participant, who was very frail and weighed 39 kilograms, moved the furniture herself as "you don't want them going back to the office and complaining that they were asked to move furniture" (02). Perhaps some flexibility in the rules would have been appropriate in this situation.

Gaps in service were also identified in the community. A major concern for one participant was the shortage of volunteer drivers. This participant was confined to her home and had great difficulty finding someone to drive her to physicians' appointments and senior's meetings. She hesitated to always ask her family as they "worry about me", whereas with a volunteer driver "it's more like an outing" (06). The handi-bus service may have filled this participant's need but she was unaware of this. Another concern for this participant was that "the little store use to...were delivering. He's gone out of business" (06). Again she was not aware that other grocery delivery services were available.

Suggestions for Improving Home Care Service

Most of the participants could not think of any improvements, "I can't see where they could have been any better" (01). Only one participant had suggestions on how she felt the service could be improved. The importance of matching the participant with the provider of care was emphasized:

> P: I think this is difficult you see where they match up people. This next one would have been absolutely wonderful for two elderly people who want who comes into

> the house and takes over. She would walk in, you see, with her own ideas of what she was going to do. Perfectly good, but perhaps not what I...(06)

The desire to have control over what the homemakers did in their homes varied among the participants. Thus attempting to meet the participant's need for control would increase satisfaction with the service.

Other suggestions for enhancing the quality of life of the home bound elderly included: a phone-in and delivery grocery service; a list of available community resources for clients; a transportation service for the handicapped; and a convalescent home following discharge from hospital (06). Having described the dimensions of satisfaction and dissatisfaction as perceived by the participants, the final question which guided this investigation is addressed.

A Comparison of the Constructs Satisfaction and Dissatisfaction

To what extent do the constructs satisfaction and dissatisfaction appear to be similar or different? Several themes fell within both the categories of 'Dimensions of Satisfaction' and 'Dimensions of Dissatisfaction'. For example, within the theme of 'Infrastructure of Home Care' elements such as accessibility of home care, consistency of care providers, adequate amounts of service, and good communication between home care workers were identified as being important in determining both satisfaction and dissatisfaction. Attributes of the homemakers and PCA's such as: trustworthy, requires little direction, willing to take direction, efficient, thorough, sensitive to client needs and appears interested in the client influenced clients' satisfaction with home care. When these characteristics were lacking, dissatisfaction was reported. Similar attributes of the nurses which contributed to clients' satisfaction were reported, such as being sensitive to client needs, willing to do extras, caring, and available when needed. Again, when these were not apparent then clients were perceived to be dissatisfied. As the same elements appear to influence both the constructs, satisfaction and dissatisfaction appear to be at opposite ends of multiple continua of dimensions. In addition, specific characteristics of the clients appear to influence their perceptions of satisfaction and dissatisfaction.

Client Attributes

Not only is it essential to be aware of what clients perceive as being important in influencing their satisfaction and dissatisfaction with home care, it is also important to understand how this elderly population view themselves and to examine how these reported client characteristics may influence their perceptions of satisfaction and dissatisfaction with home care. Four themes were identified and included within the category of 'Client Characteristics': Values, Goals, Perceived Limitations, and Perceived Social Support. These are discussed in the following sections.

Values

Values are defined as qualities held by the clients deemed to be important or worthy. Maintaining one's independence for as long as possible was a value all of the participants held, even at the risk of harming themselves. For example, one participant who was legally blind continued to do her own ironing (04) and another preferred to sponge bath herself even though it was "really a pain" (06).

Offers of assistance from home care workers or family members were often refused, "My son has wanted me to go and live with them so many times. And while I've got my independence, I'll keep it" (04). One participant expressed regret at having to give up certain functions such as banking as it was considered an invasion of privacy, "Who wants their son to know everything they've got?" (04). However, learning to accept a loss of independence was possible over time:

> P: It's a funny feeling to sit and watch somebody else do what you've done all your

> life. But you get used to it. So you accept it. But at the beginning, yes I felt very uncomfortable. (04)

Participants were concerned about being an emotional and/or physical burden to their families, friends and to home care personnel:

> P: Some days my breathing is very bad. It's easier if you haven't made any plans because if you have to tell the family, I don't want to go...or I don't feel like coming, instantly it's, "What's wrong?" (06)

* * * * *

> I: Why did you choose then to come to the lodge rather than going back to live with your step-daughter?
>
> P: Well I figured it was too much for her. Cause the wife was there at that time too, you see. Too much to do and I didn't feel I should go back there, burden her.(07)

Perhaps in an attempt to lessen the feelings of being a burden to home care, it was felt that if one could afford to pay then one should pay for the service. There was no reported displeasure at having to pay $2.00 per hour for the homemaking service.

> P: But I'm not on supplement. I have to pay. But I really...really don't mind at all. I mean the service is...the two dollars an hour, where would I get anyone to do that? ...in two hours you can't clean all the cupboards. So I've asked her to come privately. And I will pay for them to be done. (04)

Some of the participants, especially the males, preferred to hire the required help rather than asking family members for assistance. Participants hesitated to ask their children to help as they were perceived as being busy with their own work, families and recreational activities or living too far from the informant. There was also a concern that their children had enough to cope with and placing more demands on them would result in illness, "I don't want to make him sick by running him ragged" (08). In addition, the participants may have felt unable to repay family members and thus if financially able preferred to hire the required service.

If the participants felt too much was being imposed on their homemaker, family or friends a solution expressed by one participant was to request that home care "share another hour or two" (03). As well, participants initiated the termination or decrease in home care services when they were felt to be no longer needed or "I just thought that two hours could be given to somebody else that needs it more than what I do now, you know by someone else with greater needs" (02). This attitude and initiative would be appreciated by the home care coordinators who often must make difficult decisions regarding the allocation of limited resources.

Quality of life as compared to prolonging life was an expressed value. Even when the chance of survival was very low, a participant chose quality of life over extending his life.

> P: ...and being a bloody surgeon, he said, "Well, we're going to have to take your voice box". And, I said, "Well hell", I said, "To go into retirement without a voice. A man that's been in the automobile business for forty years. There's no way". I asked him what the alternative was and he said, "Oh well radiation". And I said, "Well how sure would you be of getting it there?" He said, "Well, about 10 to 15 percent". (03)

Being allowed to continue to do as much as they felt capable of doing made life worth living:

> P: You are either free and feel you have a reason to live, is to do as much as you can for yourself. And I found my daughter-in-law was taking me over and I didn't like that. (06)

A desire was expressed to spend "quality time" with their family members:

> P: My son was getting my groceries, and I felt very badly about that...Now there is a little store down here and they will deliver to seniors...It's just a wonderful service...It means when my son and his wife have time, and the weather is nice, we can go for a drive instead of spending their time...grocery shopping. (06)

The value of one's family is discussed under a following section entitled 'Informal Support'. Thus the participants' desire to remain as independent as possible, their wish to contribute to the cost of the service and their hope to enhance their quality of life are consistent with the values and beliefs of the Alberta Home Care Program and of the home care workers.

Goals

Goals are defined as the end towards which effort is directed. Goals were not discussed a great deal. As one informant stated "it would be helpful if one knew how much longer one was to live" (08), then one could plan better. Only one participant expressed any hope of his health improving. His goal was to improve his walking so that he could drive his car again, visit Las Vegas and perhaps move out of the lodge setting (07).

Another participant who realized her health would continue to deteriorate was actively attempting to find more suitable accommodation. She knew exactly what she wanted but was having difficulty finding the desired accommodation in the area in which she lived:

> P: Because I've been phoning around and looking into what's available because I don't know...What I would like is a room and a bathroom and...We have a lot of them that have little set ups that you could fix your own breakfast and lunch and go to the dining room. This is what I would like. (06)

Most participants expressed a desire to remain in their own homes, "home is best" (01).

> I: Do you have any plans...?
>
> P: No, I have none. I just thought I'd stay here. It's my home and I can do as I like. (09)

* * * * *

> P: When you get 74, every day is a bonus. No, I don't...I try not to think about that

> [moving to a long term care facility]. I wouldn't like that to happen to me, actually. No, that's a humungous thing to happen to somebody. I mean, right now, when I shut the door, this is my little house. When you are in one room, like they have at the other unit, I wouldn't like that no. (04)

Home was described as one's "grass roots" (03). For this participant his home was so important to him that he had indicated in his will that the house was not to be sold under duress but rather purchased by one of his children. One participant chose to be discharged from hospital against the advice of everyone as she had a dog and cat at home (02). Another informant credited her gradual improvement and her rekindled interest in crocheting due to being at home and no longer in the hospital setting (06). The goal of wanting to remain within the family and community environment for as long as possible is consistent with the values and beliefs held by the Alberta Home Care Program and the home care workers. Perceived limitations, which is discussed in the following section, influenced the participants' goals.

Perceived Limitations

Perceived limitations are defined as those factors which inhibit or restrain the individual in performing their daily activities or from achieving their goals. Factors such as perceived poor health and limited financial resources are included within this general theme. All but three informants appeared to be grateful for their present health status and tended to make light of their physical limitations, "I realize even, even with the little eye sight I've got, I'm very lucky" (04). An eighty-nine year old gentleman who could only hear if spoken to in a raised voice at a distance of one foot commented, "Most of the time I hear pretty good and what I don't hear don't hurt me" (09).

Some of the activities which the participants were no longer capable of performing included: travelling by plane or bus to visit family, living alone, carrying hot food or drinks, lifting things, going on outings alone, getting back into bed without assistance, going to the basement without someone in the house, driving a car, doing the heavy housework, planting the neighbour's flowers, attending church and social outings, and filling out government forms. Usually these restrictions were expressed very matter-of-factly with no apparent resentment or regret but rather as an indication of their stage of life.

But not all of the participants had adjusted to their limitations. One participant was finding it difficult accepting her recent need for continuous oxygen as she found this restricted her activities and required her to be at times dependent on others (06). Perhaps, in an attempt to decrease these feelings of dependency, she desired to maintain control over what tasks were performed by the homemakers. This informant preferred the homemaker who asked her what she wanted done that day, rather than the "homemaker who came in with her own mind what she was going to do" (06). Another participant complained of fatigue which prevented her from maintaining her social and church activities. Attempting to keep up her home and getting to her physicians' appointments took all of her energy (08). This participant appeared to be more critical of the homemakers, perhaps because she perceived that she was having difficulty managing and thus desired or expected more assistance from home care. "Frustrated" was the way one participant described his feelings in relation to his physical limitations:

> P: My only problem is...I'm so goddamn frustrated. And you can't take a man that's worked 45 years and then just throw it in. You just can't do it. (03)

A couple of participants expressed regret at having to take medications, "And I just know that I have side effects from this blinking heart thing" (08). This particular medication was blamed for her poor memory and the participant wished that her physician would "get with some of these herbal things and vitamins" (08).

Financial limitations were also a concern to the participants. The cost and the use of oxygen was cited as an expense (06). As well, one participant complained that her income was shrinking due to lower interest rates, yet expenses were rising. This informant wondered if she would be able to afford to remain in her condominium if this trend continued and she did not know if she would be able to hire the help she required with the upkeep of her home (08). For another participant, the accommodation which she preferred was felt to be beyond her financial means (06). Adjusting to or accepting one's limitations also appeared to be partially related to the participant's perceived social support.

Perceived Social Support

Perceived social support is the cognitive appraisal of being reliably connected to others. It incorporates the dimensions of perceived availability, adequacy and satisfaction with the supportive ties (Barrera, 1986). Perceived social support is examined in relation to formal and informal support systems. Home care, as part of the formal support system is not included in this discussion, as it has been previously presented under the themes entitled 'Expectations in Relation to Home Care' and 'Infrastructure of Home Care'. The sources, types and circumstances related to perceived formal and informal social support are included in the discussion.

Formal support. Formal social support is defined as a structured community-based support system which provides a particular service to a client. Often a fee is paid for this service but the support may be voluntary. Sources and types of formal support used by the participants included: Meals on Wheels; Friendly Visitor; the Volunteer Service Bureau which provided information regarding community resources; a live-in nanny who prepared meals and did housework; the Department of Veterans Affairs which provided funding to hire help with yard work and snow removal and to purchase mobility aids; the Legion which supplied a motorized scooter; mail, milk, grocery, banking and medication delivery services to the home; the handi-bus; church members who visited; a medical supply company which installed bath aids; a pharmacist who offered information; a respiratory therapist who monitored blood gas levels; hospital-based physical therapy; and general practitioners. One participant who was very adept at using available community resources commented:

> P: Like the people from the bank come up to have papers signed. My son thought it was a huge joke. He said, "Even the bank is making deliveries". And I said...I laughed...and I said, "Not only that but she said to phone if I needed a loaf of bread". (06)

It was the willingness of these service providers to be helpful and to do extras which the participants appreciated so much.

> P: I do have trouble shopping, I really

> do...But they've been so good to me. There's a young lady over there, a Jane. Somehow we got talking one day...But when I've been in the last time...she wasn't on cash. So, she was cleaning up some other things and she happened to see me and came tearing over and said, "How can I help you, Mr. Smith?"...She said, "Give me your list", which I did. Then she put the aisle...you know I kind of went through there like nothing, eh. But she was being extremely helpful. (03)

For a participant who lived in a lodge setting the availability and amenability of the staff who assisted with dressing and eating were greatly appreciated (07). From church members and friendly visitors it was the "sharing of happy family news" (06), playing a game of cards and having the garden planted (09) which were enjoyed by the participants. As well, information shared with them was valued. One participant appreciated the advice given to her by a pharmacist regarding an over-the-counter cough medicine. This same participant reported that with the pharmacist, home care nurse and respiratory therapist monitoring her, it was not necessary to visit her physician as often, as she had difficulty getting to his office (06). These examples illustrate the variety of care providers who may be involved with a client and exemplify the role each plays in enhancing and/or maintaining an individual's ability to remain in the community. In order to prevent duplication as well as gaps, it is essential that each service compliments the other in order that a seamless system of health care is delivered.

Informal support. Informal support is unstructured and is often provided by a family member or friend. The sources of informal support were: spouse, children, grandchildren, other relatives, friends and residents in the same apartment building. The types of support provided by the support network included: driving the informant to appointments and on outings, accompanying the participant on trips, grocery shopping, picking up small items from the store, mailing letters, completing government forms, offering financial advice, banking, preparing meals, sharing a meal, administering sterile dressing changes, assisting with dressing, communicating with or making a referral to a health care professional, daily checking, pouring medications into a dosette and visiting.

Generally it was felt that their informal support was "tremendous", and "without it one cannot get by" (01). Family members appeared to rally the support needed and stayed with one participant to ensure that someone was with her around the clock for many months until the strain became too great and the participant decided to move in with her daughter (05). Another participant was also living with her daughter (10), and one informant had moved from Quebec to be closer to her family (06).

However, at times the support was not appreciated. For example, one participant felt her daughter "panicked" when she did not feel well and too quickly called in the nurse (05). Only one participant expressed resentment towards her son and daughter for not providing more assistance (02) and one participant blamed her daughter-in-law for not allowing her son to help her more (08). When the informal support was lacking, then the participants appeared to expect and require more from home care. When the service was perceived to be inadequate, then dissatisfaction was reported (08).

Some participants though found it difficult to ask family members for help.

> P: When it was getting that I was...you know, near the end of my radiation, I was feeling rough. Even my sons would say, "Dad, you've got to quit looking to people for dependency". I was really hurt. Cause I was trying like a bugger, you know. But, when they said that I just thought, well that's fine, so I don't ask them to do anything for me. (03)

It was sometimes easier to hire help or ask their homemaker for assistance rather than asking a family member:

> P: If I've a homemaker come in, I pay for it and she does the work. I don't like to be the burden to the boys or to the girl. I ask them to do something once in a while, it's all right but not too much. (09)

This area was also discussed under the theme entitled

'Values'.

Whenever possible home care attempts to preserve the support provided by family and community members by assisting them in meeting the clients' health and support needs. Thus, clients' perceived social support impacts on the amount and type of service required from home care. A client with little or no social support will require more services than a similar client who has a large support network.

In summary, the participants' values, goals, perceived limitations and perceived social support all contribute to their reported satisfaction and dissatisfaction with home care. The values such as the desire to maintain their independence for as long as possible and their wish to enhance their quality of life are consistent with the values held by Alberta Home Care and the care providers. As well, the goal to remain within the family and community environment whenever possible is congruent with the beliefs of the Alberta Home Care Program and the care providers. If the participants' perceived health is poor and their social support is limited then their expectations of home care will be greater. A more global exploration of the findings and comparing these to studies reported in the literature follows in the subsequent chapter.

V. DISCUSSION

The purpose of this study was to examine what elderly clients perceive as being important in relation to their satisfaction and dissatisfaction with home care. The findings of this investigation revealed that the outcomes of client satisfaction and dissatisfaction are multidimensional constructs. The dimensions of satisfaction and dissatisfaction are related to clients' expectations, the infrastructure of home care, the attributes of the providers of care, the relationships with the formal providers of care, and clients' involvement with planning and decision making. The extent to which these dimensions were present or absent contributed to the clients' satisfaction or dissatisfaction. Thus, the findings in this study revealed that the constructs of satisfaction and dissatisfaction are at opposite ends of several continua of multiple dimensions.

A useful approach when examining outcomes, is to consider, as well as outcomes, the variations in the process of care and the structural features thought to be important in explaining and determining those outcomes (Tarlov et al., 1989). Thus, in line with evaluation research the higher order themes are discussed within the framework of structure, process and outcome as proposed by

Figure 1

Donabedian's Conceptual Framework

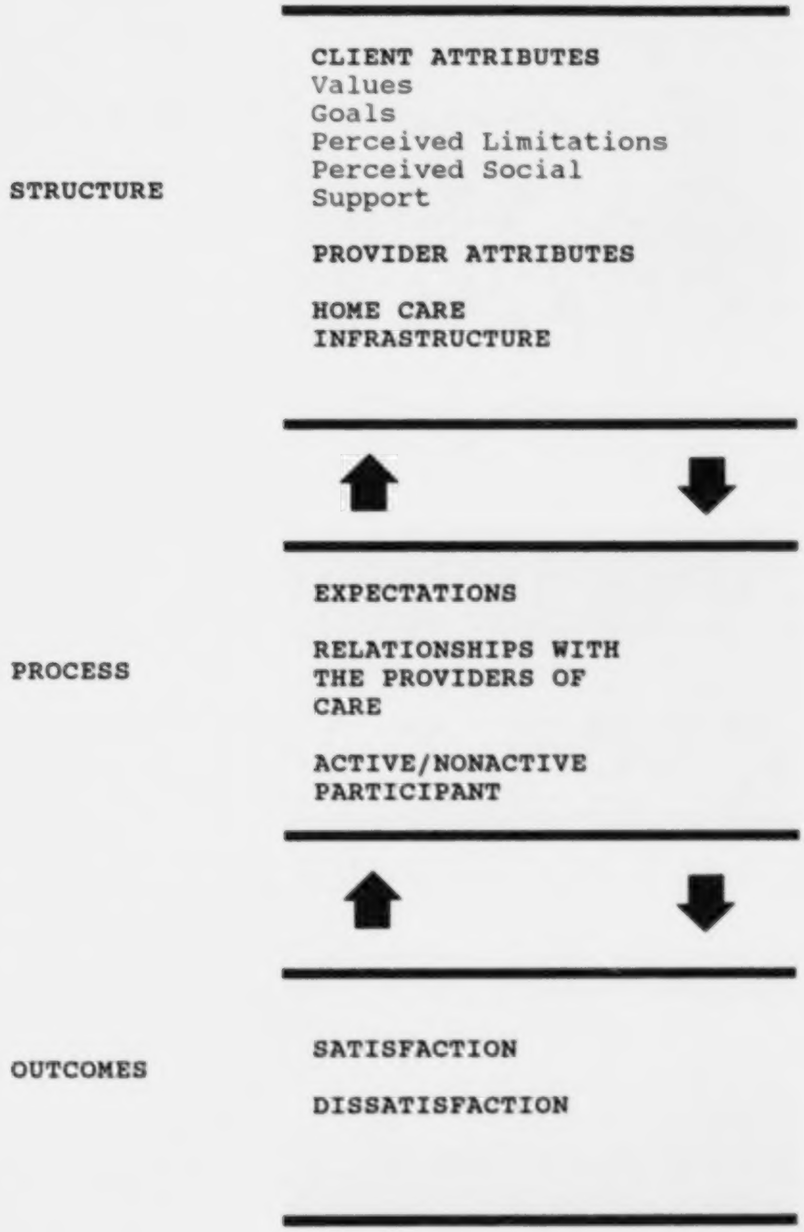
STRUCTURE	MATERIAL RESOURCES HUMAN RESOURCES ORGANIZATIONAL STRUCTURE
PROCESS	PATIENT'S ACTIVITIES PRACTITIONER'S ACTIVITIES
OUTCOME	HEALTH STATUS OF PATIENTS AND POPULATIONS

Donabedian (1988). Donabedian defines structure as "the attributes of the setting in which care occurs. This includes the attributes of material resources, of human resources and of organizational structure...Process denotes what is actually done in giving and receiving care...Outcome denotes the effects of care on the health status of patients and populations" (p. 1745)(Figure 1). For the purpose of this thesis, the structural features include the attributes of the clients, the attributes of the formal providers of care and the infrastructure of home care. Process includes the action/interaction strategies of the participants and care providers. The process aspects reported by the participants as having a bearing on their satisfaction with home care were: their expectations of home care; the relationships with the formal providers of care; and clients' involvement with planning their care. Outcomes are the consequences or results of action and interaction. Dimensions of the outcomes, satisfaction and dissatisfaction were identified (Figure 2).

In this chapter the findings are organized according to the Donabedian framework and discussed in light of the extant research findings that pertain to the identified general themes. Throughout this discussion the implications for the practice of health care providers and

Figure 2

The Conceptual Framework


STRUCTURE
CLIENT ATTRIBUTES
Values
Goals
Perceived Limitations
Perceived Social Support
PROVIDER ATTRIBUTES
HOME CARE INFRASTRUCTURE
PROCESS
EXPECTATIONS
RELATIONSHIPS WITH THE PROVIDERS OF CARE
ACTIVE/NONACTIVE PARTICIPANT
OUTCOMES
SATISFACTION
DISSATISFACTION

for further research are explicated. Five propositional statements are presented, followed by the implications for nursing practice and the limitations of the study. Finally, the findings are summarized.

Structure

Client Attributes

Client attributes which appeared to influence their satisfaction and dissatisfaction with home care included their values, goals, perceived limitations and perceived social support. Each of these themes are discussed in order.

Values. Research studies which examined the impact of the participants' values in influencing their satisfaction and dissatisfaction were not found in this beginning literature review. However, the value of independence existing among many of the elderly has been well documented in the literature (Lopata, 1979; Martin Matthews, 1991; Martin Matthews & Wakefield, 1992b). In this investigation the participants expressed a strong desire to remain as independent as possible even at the risk of harming themselves. This value is in line with Alberta's Home Care Program mission which is "to assist Albertans to achieve and maintain health, well-being and personal independence in their homes" (Alberta Health, 1992, p. 27). The values and beliefs of the Home Care

Program also state that "Albertans want and need to be as independent as possible; the autonomy and dignity of individuals should be respected; and clients have the right to participate in decisions...including the right to risk personal health and/or safety to retain independence" (Alberta Health, 1992, p. 27). Thus, this specific value held by the participants appears to be congruent with the beliefs and values held by the agency.

However, even though the values and beliefs of the Home Care Program indicate that clients have the right to risk personal health and safety, this presents an ethical dilemma for health care providers (Canadian Nurses Association, 1991). Health care professionals may feel that clients have not been adequately informed of the risks and may feel responsible for ensuring that clients receive the best possible care and thus inflict personal opinions onto clients. Gadow (1980) has clarified this dilemma by correctly stating that "the professional, while obligated to act in the patient's interest, is not permitted to define that interest in any way contrary to the patient's definition...[Rather] individuals [must] be assisted by nurses to *authentically* exercise their freedom of self-determination. By authentic is meant a way of reaching decisions which are truly one's own-decisions that express all that one believes important about oneself and the world, the entire complexity of one's values" (p. 86-87).

On the other hand, the values of the client and agency may conflict, as independence may not be valued by the client. The health care professional may perceive that the client is not interested in receiving what she/he has to offer yet feels obliged to carry out the agency 's policy, presenting an ethical dilemma (Chalmers, 1992). It has been recommended that bioethics committees be established within home care programs to provide a forum for addressing dilemmas such as this and the ethical dilemmas which result when decisions must be made regarding the distribution of limited resources (Andruski & Forbes, 1993).

The participants indicated that a reason for attempting to maintain their independence was a concern that they did not want to be a burden to their families, friends and home care. The reality is that many older seniors do need support and assistance. Indeed, the National Advisory Council on Aging (1993b) estimated that 500,000 Canadian seniors require substantial support for daily living. However, most older seniors live quite interdependently and in situations characterized by reciprocity rather than in real and total dependency. The participants' willingness to pay for the home care service, if they could afford to do so, reflects the reciprocal relationship with home care. Seniors have indicated that the really painful dependency results from needing the help of others while being unable to negotiate the terms of the help received (National Advisory Council on Aging, 1992). This underscores the importance of allowing clients to exercise a significant degree of control over the service arrangements for as long as they are able. Another value, the importance of maintaining family ties is discussed in a subsequent section entitled 'Perceived Social Support'.

Goals. The goal of remaining in one's home for as long as possible was expressed by several of the participants. This finding supports the results of a survey conducted in 1987 which found that 75% of older Canadians prefer to stay in their own homes and 20% indicated that they would consider cashing in home equity to pay for in-home care to eliminate or postpone the need to be institutionalized (National Advisory Council on Aging, 1993c). Again, this goal is congruent with the mission statement of the Alberta Home Care Program. It is posited that when the values and goals of the clients and providers of care are congruent, then clients are more likely to be satisfied with the interventions. When the values and goals differ, negotiation and compromise must occur or clients are more likely to be dissatisfied with the outcome. Further investigation is warranted to explore this proposition.

Perceived limitations. All but three informants appeared to be grateful for their present health status and tended to make light of their limitations. This is in line with the results of a survey done in 1985 in which 64% of seniors rated their health as good, very good or excellent for their age (National Advisory Council on Aging, 1993a). Perceived poor health and limited financial resources appeared to influence the participants' reported satisfaction with home care. One informant was having difficulty adjusting to her recent restricted levels of activity and desired to have more control over the tasks performed by the homemakers (06). Whereas, other participants who had perhaps greater limitations but did not perceive themselves as disabled, appeared less critical of the health care providers. This finding supports the work done by Patrick et al. (1983) who concluded that informants with a higher level of perceived disability were significantly more dissatisfied with their physician. The respondents expressed doubts about the personalized care they were receiving, including the length, concern, access, recent attention, and other aspects of the doctor-patient relationship. As well, Schada (1988) found in her study that patients with high needs were less satisfied with nursing care.

Another informant appeared to be having difficulty managing because of perceived poor health and limited financial resources. She regretted not being able to attend church and social outings (08). Again this participant was critical of the homemakers and accused them of damaging her furniture and condominium. This supports the results of the study conducted by Olsen and Fylkesnes (1991) in which a positive association between satisfaction with life in general and satisfaction with primary health care services was found. These findings underscore the importance of examining satisfaction within a broad context as the possible factors which influence satisfaction and dissatisfaction will only be determined by conducting a comprehensive and thorough assessment.

Perceived social support. The participants' families were very important to them as they provided informational, appraisal, emotional and instrumental assistance. House (1981) conceptualized the types of support within these four categories. A survey in 1985 revealed that family members and friends provide between 75% and 85% of the help received by Canadian seniors needing care in the community (National Advisory Council on Aging, 1993b). The findings in this investigation appear to provide support for previous studies which concluded that perceived social support was a significant predictor of satisfaction (Raatikainen, 1991; Rabiner, 1992). The participant who expressed the most dissatisfaction with home care had little support from her family and the community and thus expected and required more services from home care (08). Other studies have suggested that social support helps to buffer the deleterious effects of stress and those who have a supportive network adjust better (Roberts, 1984).

Other participants who had little family support compensated by being adept at utilizing available community resources (02 and 06). Two male participants preferred to hire the required help rather than ask family members for assistance (09 and 03) whereas the female participants appeared to more readily request assistance from family members prior to soliciting hired help. This finding is consistent with previous studies which found that women tend to have more family and friends in their social network, to have more frequent contact with their network members, and to receive support from multiple sources (Antonucci, 1990).

The degree of congruence between recipients' and providers' perceptions of the exchange of support can also influence the effects of support (Shumaker & Brownell, 1984). At times the participants resented the support given as it was felt to be unnecessary (05 and 06). At other times, a participant complained that her family was not supportive enough (02). Providing the appropriate amount and type of support did not appear to be an easy task and highlights the importance of open communication between all those concerned. Home care case coordinators can play a valuable role in facilitating the appropriate use of informal and formal available resources.

Attributes of the Formal Providers of Care

The attributes of the homemakers/PCA's, nurses and therapists are compared, followed by a discussion of the findings in light of the extant research findings presented in the literature. Homemakers/PCA's were described as appearing interested in the client, friendly, pleasant, thorough, efficient, flexible, trained, dedicated, willing to take direction and requiring little direction after two or three visits. Nurses and therapists, on the other hand, were described as caring, kind, concerned, understanding, offering valuable information, available when needed and providing good care. Thus, the nurses and therapists were seen as being compassionate, as a source of information and able to provide specific care. Homemakers/PCA's were considered to be friendly and able to perform certain tasks well, with little or no direction. All three groups were described as trustworthy, sensitive to client needs, willing to spend time with the participant and willing to do extras.

The reported positive characteristics of the homemakers in this investigation are consistent with the positive attributes previously reported (Martin Matthew & Wakefield, 1992a) such as: positive personality, competent, thorough, obliging, flexible, trustworthy, required no direction, positive habits and does little extras. The negative attributes previously reported (Martin Matthew & Wakefield, 1992a), focused on the homemakers' incompetency in cleaning and the necessity for the client to constantly give direction. The participants in the present investigation also reported dissatisfaction in these areas as well as with the homemaker's apparent lack of interest in the client and the inconvenience of having replacement homemakers.

The positive attributes of the nurses reported in this investigation were consistent with the work completed by Reeder and Chen (1990) and McNeese (1988). Previously reported characteristics which enhance satisfaction included: pleasantness of the nurse, listens well to the client, sensitive to client needs, provides good nursing care (Reeder & Chen, 1990) and knowledgable and capable of teaching (McNeese, 1988). The results of this investigation support Reeder's and Chen's (1990) finding that clients were least satisfied with nurses' attention to their needs. In addition, Reeder and Chen (1990) concluded that clients desire nurses to tell them about the results of tests or procedures. In the present investigation, all but one participant felt it was important that the nurse share information with them. However, for one participant, the experience of the nurse giving her information she knew about but did not want to hear was very upsetting. This underscores the importance of the nurse being sensitive to the client's individual needs and wants. No previous studies were found which examined the attributes of physical and occupational therapists in a home setting.

Infrastructure of Home Care

Organizational characteristics of home care which were identified by the participants as contributing to their satisfaction were: the consistency of care providers, the apparent training of the homemakers, the quick response to requests for service and the ability to meet individual needs of clients. Dissatisfaction was reported in relation to the amount of time the homemakers had to complete their work. This concern is presented under a subsequent theme entitled 'Expectations'. A discussion of the characteristics of home care which contribute to satisfaction follows.

First, the reported consistency of home care workers conflicts with previous research results which estimated an annual turnover rate among personal care workers at 60 to 70% industry wide (Feldman cited in Applebaum & Phillips, 1990). Major causes of attrition among homemaker-home health aides included low pay and lack of benefits, lack of recognition and opportunity for advancement, feelings of isolation, burnout related to job stress, and personal problems (Canalis, 1987). The consistency of home care workers identified in the present investigation may reflect the current economic climate and may be related to the substantial number of homemakers and PCA's coming from suburban or rural areas.

Second, although the participants were pleased with the apparent skills and knowledge level of their home care workers, previous research has reported that homemakers themselves expressed a need for more specialized training in a variety of areas (Martin Matthews & Wakefield, 1992a). With the rapid expansion of home care related to the early discharge of clients from acute care settings and to the emphasis on maintaining individuals in their homes and preventing institutionalization, the health and social needs of the clients have become increasingly complex, necessitating the need for enhanced skills and knowledge levels of home care workers. However, little evidence exists to suggest the optimum hours of training necessary or the methods or curriculum needed by home care workers (Applebaum & Phillips, 1990).

In addition, further research is required to examine quality of life issues of severely handicapped clients on home care programs. For example, Hazlett (1989) found that the majority of mothers of ventilator-assisted children reported that the home care of their child was very stressful because the required support systems were not available. As well, families who are caring for individuals at home may experience a tremendous financial burden, as the cost of equipment and medications which are covered in acute care settings are the responsibility, at least partially, of individuals once discharged from hospital. In addition, although it has been assumed that it is less expensive for individuals to be in their own homes, this may not be the case when one considers the travelling time, the health professionals' fees and the amount of care required by some individuals, such as the ventilator-assisted children. Indeed, Clarfield (1983) suggests that with greater levels of disability, hospital care becomes the most economically efficient alternative. Further research is needed to determine the cost effectiveness of maintaining individuals with high levels of need in their own homes.

Third, some participants reported a quick response from the case coordinators to requests for initiating or increasing service, however, others claimed they did not know their case coordinator's name and were unsure of how to contact her. In addition, there were inconsistencies in the tasks the homemakers were willing to do, such as moving furniture and washing the inside of windows. This finding is consistent with the work completed by Martin Matthews and Wakefield (1992a), which indicated that in most instances the clients did not know what they could ask homemakers for, nor what work standard to expect from the homemakers. The institution of quality assurance levels would permit clients to have an idea of what to expect. Informing the clients in writing of the name of the case coordinator and how she can be contacted, plus the standards expected of the home care workers (perhaps in the form of a picture scrap book), during the initial assessment visit, and whenever required thereafter, would be a positive step in assisting clients in understanding the potential of the home care service and in evaluating the service.

However, home care agencies interested in implementing quality assurance systems have little to begin with, as there is virtually no research base indicating which interventions are most effective and cost-efficient

(Applebaum & Phillips, 1990). In addition, instruments which measure client outcomes need to be refined and standardized in order to enhance their useability and to allow results to be compared across settings and populations. Improvement is also needed in our ability to classify, store and retrieve information. Establishment of Health Information: Nursing Components will provide accessible data nation wide to nurse investigators and their partners in health care who are conducting outcomes research (Forbes, 1993).

Process

The themes included within process which appeared to have a bearing on the participants' satisfaction and/or dissatisfaction with home care were: their expectations of home care; the relationships with the formal providers of care; and clients' involvement with planning their care. A discussion of each of these themes follows.

Expectations

An examination and comparison of the findings which related to the participants' expectations of the three groups of formal providers of care (homemakers/PCA's, nurses and therapists) is presented, followed by a discussion of the findings in light of the extant research findings identified in the literature review. Having a cheerful manner was felt to be very important for all three groups and being trustworthy was also considered to be highly important for the homemakers/PCA's and therapists but not as important for the nurses. Because nurses were always in the presence of the participants, this characteristic was not as essential as it was for the homemakers who were often not within sight of the participants and who had access to their property. This exemplifies the feeling of vulnerability of the clients as care is provided not only away from public view but away from their view.

Appearing interested in the client, knowledgable, providing good care and willing to answer questions were attributes felt to be very important for nurses and therapists to possess but not as important for the homemakers/PCA's. However, being efficient, thorough, having the same homemaker/PCA each visit, and willing to take direction were all important homemaker/PCA attributes. Willingness to become a friend was considered to be more important for the homemakers/PCA's than for the nurses, although not highly important. The role of the homemakers/PCA's was thus viewed differently from the role of nurses and therapists. The nurse's and therapist's primary focus was the client, whereas the homemaker's focus was the client's environment. Nurses and therapists were expected to possess specific knowledge and skills from which the client could benefit and were not expected to develop a "friend" relationship with the clients. Being sensitive to the client's needs and able to communicate well were considered to be very important attributes for all three groups. Willingness to do extras and being punctual were attributes which were not expected of both the homemakers/PCA's and nurses.

In this beginning literature review no other studies were found which examined clients' expectations of home care. However, other researchers have investigated expectations in relation to other services provided (Abramowitz et al. 1987; Field, 1984; Hsieh & Kagle, 1991; E.J. White, 1988). Field (1984) examined client care-seeking behaviours and client response to nursing care in a community health setting. Three of the five propositions suggested by Field were as follows: 1) "clients who receive care which is congruent with their expectations will feel satisfied with the intervention whether or not their problem has been solved; 2) clients who receive care that is perceived as divergent from their expectations will be ambivalent about or dissatisfied with their care even when progress toward their goal has been achieved; and 3) clients who cannot identify their problems or who have no definite expectation of care...will be ambivalent or dissatisfied with care given" (p. 260). The other two propositions suggested by Field are related to the client's inner control and are discussed in the following section entitled 'Relationships with the Formal Providers of Care'.

The findings of the present investigation appear to add support to the first two propositions. When the participants were asked to rate in importance what they expected in relation to the health care providers, these same characteristics were reported spontaneously during the interviews as contributing to their satisfaction or dissatisfaction with home care. For example, the attribute of trustworthiness was rated as being very important but when lacking, then dissatisfaction was reported. If on the other hand, an attribute such as sharing information was felt to be unimportant, yet was demonstrated by the care provider, then the participant was dissatisfied. When there was congruency between the expected characteristic and what was provided then satisfaction was reported. Support for the third proposition was not provided in this investigation as all of the participants were able to articulate which characteristics in the health care providers were important to them in determining their satisfaction.

This suggests that the care providers must be alert to the expectations which the clients have of them as these are more important in determining satisfaction than progress toward a stated goal (Field, 1984). For example, in this investigation dissatisfaction was expressed in relation to the little time the homemakers had to complete their work. This finding supports the results of the study conducted by McNeese (1988) in which the participants suggested more services were required for a longer period of time in order to meet their homemaking and personal care needs. With the current fiscal restraints it is perhaps even more important that clients' expectations be explored and understood so that they can be realistically established and be consistent with the care provider's and agency's expectations.

Relationships with the Formal Providers of Care

The relationships which developed with the formal providers of care appeared to be related to the frequency of contact, the intimacy of the care provided, the social needs of the participants and the knowledge and skill levels of the provider of care. PCA's were referred to as "friends" or "like family", whereas the relationships with the homemakers were often more business-like. The nurses were considered to be "friendly visitors" and "casual friends" and one participant described his therapist as "like a mother". The question that arises is whether there is a difference between a friend and a professional. Field

(1984) suggests that it is the nurse's knowledge base that differentiates her role from that of a friend. Gadow (1980) identifies that the professional, unlike the friend, is able to maintain for the client/patient the one perspective toward her experience which is the most difficult for her to develop, sustained objectivity. The orientation of the professional is toward the typical rather than the solitary.

Bergum (1993) advocates a nurturance model of interaction. She posits that knowledge for ethical clinical judgement must evolve through three ways of knowing: 1) knowledge of subjective experience (listening to clients' experiences); 2) deliberate or objective abstraction (technological thinking and rationality); and 3) participation (focusing on understanding human experiences). The providers of care must be participants who are willing to risk responding authentically to clients. Subjective information is revealed by clients and objective information is provided by health care professionals, with the focus on understanding what meaning the experience has for the clients. This model would be useful in home care settings as well as other settings.

Based on the findings in this investigation and in the literature, it is posited that with greater knowledge and skill the formal provider of care has enhanced ability to bring to the relationship an objective, generalist perspective and is better able to understand the client's subjective experiences. Together, the client and care provider interpret the situation and explore alternatives. Objectivity transcends the care provider's subjectivity. Thus, the providers of care who have less educational preparation and experience will develop relationships with clients which reflect more closely "friend" relationships, rather than therapeutic relationships.

There was apparent a reciprocal nature to the relationships as gifts were often exchanged between the participant and care provider. The gift-giving by the participants appeared to be for the purpose of reciprocating the home care workers. Gifts to reciprocate the professional provider was one of five categories of gift-giving identified by J.M. Morse (1990).

Eustis and Fischer (1991) concluded in their study that the relationships between clients and homemakers were asymmetrical as clients were more likely to say they could talk about their personal problems with their homemakers than homemakers were to say that they could confide in their clients. Whereas, Martin Matthews and Wakefield (1992b) suggested that the relationships were symmetrical as both clients and homemakers reported that they discussed family matters with each other. Chalmers (1992) developed a 'Giving and Receiving Theory' which focused on the interactive processes between health visitors and clients. The health visitor 'gives' her service and in exchange the client is expected to 'give back' information, act on instructions and advice, and appear interested. The symmetry of the relationships was not examined in the present study as only the clients' perspectives and not the providers' perspectives were revealed. However, for reasons outlined above, it is posited that the more advanced the knowledge level and experience of the health care providers, the greater will be their skill in assisting clients in meeting their needs and in turn, the rewards received will be larger. For example, nurses have more skill in focusing on and responding to the complex needs of clients from a generalist and holistic perspective whereas homemakers have skills in meeting specific clients' needs.

Eustis and Fischer (1991) also suggested that the personal bonds developed may be problematic for both the clients and homemakers as the clients may feel loss of control as employers and managers of their care and the homemakers may feel exploited as their work extends beyond their job description and normal working hours. The present investigation did not support this conclusion as participants did not express a loss of control when personal relationships developed. Rather the issue of control appeared to be related to the stage of adjustment to the client's disability. If participants were having difficulty adjusting to recent restrictions or limitations then the issue of controlling what the homemaker did in their home appeared more important. Perhaps having a sense of control over one's home was an attempt to maintain control of their lives.

In addition, if the participants appeared to lack inner control and were having difficulty making decisions in relation to other aspects of their lives, they seemed to have difficulty in relaying concerns or complaints to the homemakers. Field (1984) posits that clients who lack inner control over their daily activities will expect the nurse to act as an authoritarian figure who exerts control, whereas clients who perceive themselves as having inner control will expect guidance and support from the nurse. Thus, home care workers must be sensitive to clients' need to control and to their perceived strengths and to work with these. Further research is warranted to examine the relationships between clients and care providers, and to determine how best to promote and to monitor these relationships.

Active and Nonactive Participant

An unexpected finding of this investigation was the participants' lack of involvement in the planning of their care, especially while hospitalized. The participants preferred that the health care professionals make the decisions for them due to their poor health at the time and because they were not aware of what they would require once discharged home and admitted to home care. This finding does not support previous studies which examined this issue. For example, Ervin, Walcott-McQuigg, Chen, and Upshaw (1992) found client perceived affective support, health information adequacy and decisional control to be significantly correlated with adherence to the prescribed regimen, having fewer and/or less severe symptoms and having more positive well-being. Ferrell et al. (1992) asked bone marrow transplant survivors how doctors and nurses could enhance their quality of life, and the theme 'Increase Patient Participation in Decision Making' was identified. Degner and Sloan (1992) suggested that the impact of being diagnosed with a life threatening illness may influence preferences to participate, as they found that 59% of patients wanted physicians to make treatment decisions on their behalf, whereas 64% of the public thought they would want to select their own treatment if they developed cancer. It should be noted that the participants in these studies were not necessarily elderly as the age criterion was over 18 years.

Perhaps the finding in the present investigation is a reflection of this population's inexperience in participating in decisions which affect their health and/or related to the health care professional assuming the "expert" role. Indeed, the role of the health care provider is to enhance clients' self-determination. This is accomplished by assisting clients to discern and clarify their beliefs, values, and goals and by providing objective information so that clients can make optimal treatment decisions. Clients may need assistance in integrating personal wishes with medical information, under conditions as free as possible from emotional bias, so as to achieve the best understanding of possible alternatives. When clients are not encouraged and assisted to exercise their freedom, they cannot be autonomous (Gadow, 1989).

Outcomes

Outcomes are the consequences or results of action and interaction. Satisfaction and dissatisfaction with home care are the outcome themes addressed in this investigation. A discussion of the dimensions of satisfaction and dissatisfaction follows.

Satisfaction and Dissatisfaction

This in-depth, longitudinal study revealed that structural and process factors impact on the outcome of client satisfaction and dissatisfaction with home care. The findings offer support to the premise that client characteristics such as values, goals, perceived limitations and perceived social support may influence their perceptions of satisfaction and dissatisfaction with home care. These in turn appear to contribute to their expectations of home care. If the client's values, goals and expectations are congruent with the agency's and the health care provider's values, goals and expectations, then the client is more likely to be satisfied. In addition, if the client perceives her/his health to be poor and/or to have limited social support then the client will more likely have higher expectations of home care. Due to time and fiscal restraints, health care providers may not have the luxury of attempting to understand in-depth the determinants of clients' expectations, however, an exploration of expectations is essential.

Attributes of the providers of care and the infrastructure of home care also influence client satisfaction with home care. Having a cheerful manner and trustworthiness were perceived as being very important to the participants in influencing their satisfaction and dissatisfaction. These findings are consistent with other findings (Eustis & Fischer, 1991; Martin Matthews & Wakefield, 1992b). Since home care services are provided in the client's private domain, the issue of trust is more salient than in most other professional relationships (Eustis & Fischer, 1991). The identified important characteristics of the infrastructure of home care were those which allowed the agency to: provide consistent home care workers to clients when a compatible fit had been found; be easily accessed by the clients; respond quickly to clients' requests; and be flexible in order to meet clients' individual needs.

However, the interpersonal skills of the formal care providers and their ability to provide more personal care were identified as the most important dimension of satisfaction. For example, the care provider's friendliness, sensitivity to the participant's needs and wishes, and willingness to do extras were identified as being important sources of satisfaction and dissatisfaction. Eustis and Fischer (1992) found that the complaints clients talked about most were not related to job performance but rather in relation to the interpersonal dynamics of the relationships. In the study conducted by Martin Matthews and Wakefield (1992b), the personality of the homemaker was identified as a major factor contributing to satisfaction. Additionally, Eriken's (1983) study which reported predominantly inverse relationships between quality of nursing care and patient satisfaction, exemplifies the importance of the interpersonal skills of the health care provider, as patients who were oriented to the environment and were treated courteously were more satisfied than those patients who had received good physical care and taught self maintenance skills.

The constructs satisfaction and dissatisfaction have been shown to be multidimensional. The dimensions identified in this investigation did not completely support the dimensions of patient satisfaction with doctors and medical care services reported by Ware et al. (1978), since physical environment and finances were not found to be dimensions of satisfaction within the home care setting. Similarly, the dimensions of satisfaction with hospital care such as admissions, hospital environment, medical care and discharge/billing as revealed by Hays et al. (1990) were not supported in this investigation. However, attributes of the nurses such as concern, caring, friendliness, respect, individualization, competence, skill, coordination, and information given (Hays et al., 1990) were similar to the characteristics of home care workers identified by the participants in the present investigation. This demonstrates that some of the dimensions of satisfaction are specific to the setting in which care is received while other dimensions appear to cross settings and health care providers. The findings from the present investigation supported the dimensions of client satisfaction with nursing care in home health care as identified by Reeder and Chen (1990). The dimensions reported by Reeder and Chen were: availability of care, continuity of care, provider competence, personal qualities of the provider and general satisfaction.

In addition, the elements which influence the constructs satisfaction and dissatisfaction appear to be the same. Previous research suggested that the two constructs may be different as high ratings of satisfaction were frequently accompanied by complaints (La Monica et al., 1986). However, this may have been a reflection of the questionnaire not addressing those features which were salient to the clients, rather than the constructs being different. Indeed, the findings of this investigation provide support for the premise that satisfaction and dissatisfaction are at the opposite ends of several continua of multiple dimensions.

Propositional Statements

Further research is required in order to fully understand the constructs satisfaction and dissatisfaction and to identify those elements which influence clients' satisfaction with home care. However, a number of propositional statements can be derived from this investigation. Five tentative propositions and examples which substantiate each statement are listed below.

1. When congruency exists between clients', formal care providers', and the agency's values and goals then clients are more likely to be satisfied with the care received from home care.

Independence and the desire to remain in one's own home were valued by the participants, health care providers and the home care program. One informant terminated her homemaking service as "I just thought that two hours could be given to somebody that needs it more than what I do now, you know by someone else with greater needs" (02). With the current fiscal restraints, such values and goals are encouraged by care providers and home care agencies.

2. Clients' values, goals, perceived limitations and perceived social support impact on their expectations of home care. Expectations in turn influence clients' satisfaction and dissatisfaction.

Clients' desire for independence and their wish to remain within the family and community environment for as long as possible impact on their expectations of home care, as it was expected that home care would assist in achieving these values and goals. If the participants perceived their health to be poor and perceived their social support to be limited then their expectations of home care were higher. Clients who received care congruent with their expectations reported satisfaction with the care received. Clients who received care which was divergent from their expectations were dissatisfied. For example, the attribute of trustworthiness was rated as being very important and when lacking, dissatisfaction with home care was the outcome.

3. With greater knowledge and skill the formal provider of care has enhanced ability to bring to the relationship an objective, generalist perspective and is better able to understand the client's subjective experiences. Objectivity transcends the provider's subjectivity. Together, the client and provider of care interpret the situation and explore alternatives.

The attributes important for nurses and therapists to possess included providing good care, willing to answer questions, knowledgable and appearing interested in the client. Being thorough, efficient and willing to take direction were all important homemaker/PCA attributes. Thus, nurses and therapists were expected to possess specific knowledge and skills from which the client could benefit. The homemakers were expected to demonstrate skills in relation to the client's environment.

4. The most important elements of satisfaction and dissatisfaction are the interpersonal skills of the individual providers of care and their ability to provide more personal care.

Cheerfulness was consistently reported to be a highly important attribute for all of the formal providers of care. In addition, the following attributes: appears interested in the client, listens well, communicates well, provides valuable information and is sensitive to client needs enhanced satisfaction with home care.

5. Satisfaction and dissatisfaction are multidimensional constructs which occur at opposite ends of several continua of multiple dimensions.

The dimensions of satisfaction and dissatisfaction as revealed in this investigation included clients' expectations, the attributes of the providers of care, the infrastructure of home care, the relationships developed with the formal providers of care and clients' involvement in planning their care. In addition, client characteristics such as values, goals, perceived limitations, and perceived social support appear to influence clients' perceptions of satisfaction and/or dissatisfaction with care received. The presence or absence of a particular element appears to contribute to the degree of satisfaction. Thus, the constructs of satisfaction and dissatisfaction appear to be at opposite ends of several continua of multiple dimensions.

Implications for Nursing

Based on the findings of this investigation, implications for home care workers in general have been presented throughout the discussion section. However, because nursing makes up the largest professional body of home care workers, the implications related to nurses are summarized for clarification. First, the findings demonstrated the important role nurses have in assisting clients to exercise their freedom of self-determination by becoming clear about their values, goals and expectations in relation to home care and by offering needed information so that clients are able to make informed decisions. In addition, the importance of establishing congruency between the client's expectations and those of the nurse and agency was presented.

Second, nurses, as case coordinators, are in an ideal position to facilitate the appropriate use of formal and informal support. Case coordinators are knowledgable regarding available community resources and can ensure that clients are made aware of the required services. This investigation revealed how difficult it is to obtain a balance between clients' desire for support and the type and amount of support offered. Nurses can assist in establishing congruent goals and expectations by facilitating open dialogue among all those involved with clients so that a balance is achieved.

Third, the factors which are important in determining client satisfaction and dissatisfaction with home care have been identified. Nurses, as well as other partners in health care, must recognize the value of incorporating these factors, such as the provision of care which is more personal, when implementing the delivery of care. The interpersonal skills of the providers of care must be promoted and the means to monitor them must be developed. The findings also revealed the importance of being alert to the expectations that clients have of providers of care, as only when there is congruency between expectations and care provided will clients be satisfied.

Fourth, nurses are well-suited to participate in creating healthy public policy. Healthy public policy, for the purpose of this thesis, includes not only government policies as Milio (1986) advocates but also organizational policies as suggested by Lemieux cited in O'Neill (1989/90). As front-line workers nurses are sensitive to the needs of individuals and aggregates. The findings in this investigation revealed that it is essential that adequate support systems are in place if clients with complex health and social problems are to be maintained in the home setting. The educational preparation of the formal care providers must also keep pace with the greater skills required. Financial support, educational leaves, inservices and programs must be available to those nurses who wish to further their education. Nurses should lobby and articulate the needs' of their clients as well as their own educational needs to ensure that funding is targeted at these areas. In addition, the establishment of bioethics committees within home care programs would provide a forum whereby ethical dilemmas can be addressed by nurses, clients, and other partners in health care, prior to the development and implementation of policies.

Lastly, the findings also revealed several areas which require further research, such as developing and/or refining instruments which measure client outcomes, including client satisfaction and examining and comparing the effectiveness of nurse-client interactions with the relationships developed between clients and other care providers. However, in 1990 Canada spent close to 9 billion dollars on nursing services, yet less than 1% of the total health research dollars was spent on nursing research (Smith, 1993). In addition to lobbying for healthy public policies, nurses should lobby funding agencies to increase the amount of nursing research dollars. Nurses will take up the challenges and seize the opportunity to play a vital role in addressing and solving these and other issues which face the clients on home care and the nurses who work in partnership with them.

Limitations of the Research

In order to answer the research questions, an exploratory design was utilized. Several themes were identified which are important in influencing clients' satisfaction and dissatisfaction with home care. Generalizability of the findings was not the goal of this investigation, rather the goal was to describe and understand the *meaning* of central themes in the life-world of the participants (Kvale, 1984). However, a qualitative, exploratory design does permit empathic generalizability. Findings are valid to the extent that they resonate with the experiences of others who have experienced the phenomenon in question (Osborne, in press). The utilization of the scenarios to verify the identified themes among all of the participants and asking the informants to rate in importance the identified characteristics of the care providers were means by which the generalizability of the findings were enhanced. The scenarios appeared to limit socially desirable responses and proved very revealing as the informants were able to relate to them and readily offered their opinions of how satisfying the experience would be for them. Their views and expectations of home care and of their care providers became obvious from the subsequent discussion. The scenarios also provided the informants with some insight into how other clients determined their satisfaction with home care. In addition, having shared the findings with other home care nurses and with clients on home care, the investigator has been impressed by the apparent "goodness of fit" of the findings for these individuals.

However, the specific characteristics of the participants may limit the empathic generalizability of this investigation. As all of the informants were 65 years of age or older, the findings of this study may not apply to clients in other age groups. Indeed, from the researcher's own experience and from the results of studies reported in the literature, younger clients may report higher levels of dissatisfaction with home care (Carmel, 1985; Hall & Doran, 1990; Pope, 1978; Raphael, 1967). Factors which influence satisfaction and dissatisfaction with other age groups warrants further investigation.

The literature also suggests that caregivers (formal and informal) and clients derive their satisfaction from different perspectives (Lavizzo-Mourey et al., 1992;

Schmele, 1985). As home care attempts to support informal caregivers in maintaining clients in their homes, caregivers' perspectives are also vitally important. Thus, elements which influence caregivers' satisfaction with home care warrants further research.

Another possible sample bias arose due to the poor response rate as 120 introductory letters were mailed and only 20 clients responded. The investigator has no information on the clients who did not reply to the letters. It is therefore impossible to compare the characteristics of those who responded with those who did not. Although the findings of this investigation are not generalizable, several propositional statements have emerged which can be subjected to testing in future research.

Summary

An inductive, longitudinal, exploratory design was utilized in this investigation. To date, clients' perceptions of the elements which are important in influencing their satisfaction and dissatisfaction with home care have not been investigated. Satisfaction instruments presently available have not been found to be useful, perhaps because the elements which clients feel are salient to them are not being addressed.

The findings of this study indicate that structural features and process aspects influence the outcomes of satisfaction and dissatisfaction. The themes identified which fell within the structural framework were clients' values, goals, perceived limitations and perceived social support. The participants' and home care program's values and goals appear to be congruent as both value independence and desire that the client remain within the family and community environment for as long as possible. Values, goals, perceived limitations and perceived social support influenced the participants' expectations of home care. The theme entitled 'Expectations' was included in the 'process' framework. Support was provided for Field's (1984) proposition that clients who receive care congruent with their expectations will feel satisfied with the care, whether or not their problem has been solved.

The themes entitled 'Attributes of the Formal Providers of Care' and the 'Infrastructure of Home Care' also fell within the 'structure' framework. Having a cheerful manner, being sensitive to the client needs, and demonstrating trustworthiness were attributes of the providers of care considered to be very important by the participants. Characteristics of the home care agency which were important included providing consistent, skilled home care workers, who were accessible and who had some flexibility so that the individualized needs of the clients could be met.

'Expectations', 'Relationships with the Formal Providers of Care' and 'Active and Nonactive Participant' were the general themes identified that pertained to 'process'. Participants described their PCA's as "friends" or "like one of my own", whereas the relationships with the homemakers often appeared more business-like. Nurses were considered to be like "friendly visitors" or "casual friends". It was posited that with greater knowledge and skills the formal provider of care has enhanced ability to bring to the relationship an objective, generalist perspective and is better able to understand the client's subjective experiences. Objectivity transcends the provider's subjectivity. Together, the client and care provider, interpret the situation and explore alternatives. Thus, the provider of care who has less educational preparation and experience will develop a relationship with the client which reflects more closely a "friend" relationship, rather than a therapeutic relationship.

An unexpected finding was the participants' desire to have little or no involvement in decisions which affected them, especially as patients in an acute care setting. Perhaps this finding is a reflection of the inexperience this population has had in the past with participating in those decisions which affect their health and/or is related to the "expert" role assumed by the providers of care. This underscores the important role nurses, and other partners in health care, play in enhancing clients' self determination by working with rather than for clients.

The outcomes of satisfaction and dissatisfaction have been shown to be influenced by multiple elements. For ease of understanding these were classified within the structural and process framework. The constructs of satisfaction and dissatisfaction appear to be at opposite ends of several continua of multiple dimensions as the same elements influence both satisfaction and dissatisfaction. Further research is required to fully understand the constructs. However, elements which are important in influencing client satisfaction and dissatisfaction with home care have been identified and five propositional statements have been generated from this investigation. It is hoped the findings of this study will provide a sound basis for the refinement, or if needed, the development of a client satisfaction instrument.

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APPENDIX A

INTRODUCTORY LETTER

Dear Sir or Madam:

I am writing to inform you about a research study being conducted by Dorothy Forbes, a Master of Nursing student at the University of Alberta. As someone who is presently receiving service(s) from Home Care, you are in an ideal position to offer some helpful ideas to Mrs. Forbes about what is satisfying or dissatisfying to you about Home Care services. What makes you satisfied or dissatisfied is of interest to those who provide services to you. The knowledge gained from this study will assist those who provide services to include what makes you satisfied with Home Care.

Taking part in the study is completely voluntary. If you agree to take part, two or three interviews will be held in your own home. Each interview will last about one hour and will be tape recorded. Your eligibility for Home Care services will not be affected by whether or not you take part in the study. Your name and the information you provide will be kept confidential. Your individual responses will not be made available to the Health Unit or to home care staff. Your comments will NOT be used to "check on" the people who are caring for you.

If you are interested in taking part or in receiving more information about this study please contact Dorothy Forbes at 458-8055 or return the enclosed postcard.

Thank you for your time and for thinking about taking part in this research study.

Sincerely yours,

Director of Home Care

APPENDIX B

CONSENT FORM

Project Title: Satisfaction and/or Dissatisfaction as Perceived by Elderly Clients on Home Care.

Researcher:	Thesis Supervisor:
Dorothy Forbes BNSc.	Dr. Anne Neufeld
M.N. Candidate	Professor,
Faculty of Nursing	Faculty of Nursing
3-134 CSB	5-134 CSB
U. of A.	U. of A.
T6G 2G3	T6G 2G3
492-8192	492-2699

The researcher is a graduate student in the Master of Nursing (M.N.) Program at the University of Alberta. The study is part of the requirements for the M.N. degree. All those who provide Home Care service are interested in ways of improving the services. However, little is known about client satisfaction and/or dissatisfaction with Home Care. This study has been planned to meet this need by asking clients about their experience with Home Care.

I understand that if I take part in the study I will be interviewed two or three times. These interviews will be tape recorded. Each interview will take about one hour.

The researcher is not employed by the _______________. She will not share my individual responses with the health unit staff. Information provided to the staff will be presented as a group response to protect my identity. My name will not appear in any report or document. Only a code name will appear on the interview forms. My responses will be kept in a locked drawer and kept for a minimum of seven years. If any further use is made of the data, the proposal will first be submitted to an ethics committee for approval. I understand I can withdraw from the study at any time by telephoning the researcher or Thesis Supervisor. My decision not to take part will not affect the service(s) I presently receive from Home Care. If the researcher becomes aware that I have been harmed or am at future risk, she will notify the Case Coordinator. Prior to taking this action the researcher will discuss her concerns with me.

Although I may not benefit from the study directly, the information obtained will help Home Care to provide better services in the future.

THIS IS TO CERTIFY THAT I, ______________________________ have given my consent to take part in the above research project. I have received a copy of the consent form.

Any concerns or questions I have about the study may be directed to the researcher, Thesis Supervisor, or Director of Home Care.

------------------------------ -----------------------
Signature of client Date

------------------------------ -----------------------
Signature of researcher Date

I would like to receive a summary of the study when it is finished.

Yes _______ No ________

APPENDIX C

CLIENT BIOGRAPHIC DATA FORM

Code number:_______________ Date: ____________

Age:________________

Gender:
- 0 - male
- 1 - female

Marital status:
- 1 - never married
- 2 - married
- 3 - widowed
- 4 - separated
- 5 - divorced
- 6 - common-law

Most recent occupation:_____________________

Most recent occupation of spouse: _______________

Place of residence:
- 1 - own home/apartment
- 2 - senior's lodge
- 3 - other (please specify)

Length of time in this residence: (in months) ____________

Total number of persons living in home: _____________

Spoken languages other than English: _____________

Highest level of education completed: ____________

Diagnosis: ______________________

Length of time on Home Care: (in months) ________

Number of days in active treatment hospital in the last six months: ___________

Number of days in other health care institution(s) in the last six months: ___________

Number of visits to physician in last six months: ________

Are you presently waiting for a bed in a Long Term Care Facility?

- 0 - yes
- 1 - no

If yes, number of days on wait list: ___________

Services received from Home Care: (please circle all services received)

- 1 - nursing
- 2 - homemaking
- 3 - personal care aid
- 4 - occupational therapy
- 5 - physical therapy
- 6 - respiratory therapy
- 7 - social work
- 8 - volunteer

Other services used by client in the community: (please circle all services used)

- 1 - meals on wheels
- 2 - social day program
- 3 - social service
- 4 - physiotherapy
- 5 - psychiatric/psychology/mental health
- 6 - physician
- 7 - other, please specify ____________________

APPENDIX D

GUIDING QUESTIONS

The guiding questions were used to assist in systematic data collection. The questions were not necessarily asked in the form or order listed below.

* Tell the story of how you came to be involved with home care.

Probes: How long have you been on the home care program?
What services do you receive and how often?
In what areas does home care provide assistance to you?

* Tell me what it is about home care that you find satisfying?

* Tell me what it is about home care that you find dissatisfying?

* Please describe an actual situation or experience which illustrates what is most important about home care for you?

* Please describe an actual situation or experience which illustrates what you find dissatisfying about home care.

* What would an "ideal" home care experience include?

* Do the services you receive give you what you expect? In what ways?

* Has home care assisted you to remain in your own home? Has home care improved your quality of life in any way? Please describe.

* In what ways have you been involved in planning your care? [type, amount and frequency of service provided] Have you been involved in the planning of your care as much as you would like? Please explain.

* How would you describe the services you receive? [i.e. suitable, adequate, consistent, flexible, informative, offered in a caring manner and individualized or the opposite]

* In what ways could the home care service(s) you receive be improved?

* What other services/programs/options [i.e. housing] would be helpful to you?

* In addition to home care, do you receive support from family, friends, relatives, other professionals or health care agencies? In what ways is this support offered?

APPENDIX E

SCENARIOS

1. Mrs. A., a 76 year old lady has been in hospital for several months. She tires easily and her memory is poor but she is anxious to return home even though she lives alone. The home care coordinator assesses her and sets up homemaking service. No information is obtained from Mrs. A. in relation to what she feels she will need once she is home. Mrs. A. is satisfied with the arrangements made.

If you were Mrs. A. would this represent a satisfying experience to you? Please explain your answer. When, if ever, would you expect to be more involved with planning the services you receive from home care?

2. Mrs. B. is 89 years of age. She receives homemaking service and a bath assist every week by two different workers. Frequently these workers are replaced by different workers and Mrs. B. finds she has to explain to each new worker what it is she wants done.

Has this ever happened to you? If so, how did you feel about it? If not, how do you think you would feel about having one or two new workers each week?

3. Mrs. C. has become very good friends with her homemaker. The homemaker seems to know exactly what Mrs. C. needs without being told and will do extra little things for Mrs. C. such as mailing her letters. Mrs. C. thinks of her homemaker as she would a family member. Personal information is often shared between them.

Is this the type of relationship you have with your home care worker(s)? If not, in what ways is your relationship with your home care worker(s) different from this one? In what ways is this relationship the same as the kind of relationship you would like to have with your home care workers? In what ways is this relationship different from the kind of relationship you would like to have?

4. Mr. D. was not sure what to expect from his homemaker. He found that she was very willing to do whatever was asked of her and even did more than was asked. For instance, she would take mending home with her if she did not have time to complete it while at Mr. D.'s. Although Mr. D. appreciated this he was concerned that he may be asking too much of his homemaker.

Have you ever been in a situation like this? If so, in what ways were your feelings the same as Mr. D's? Different from his? If not, in what ways do you think you would have the same feelings as Mr. D? Different feelings? Do you have any suggestions for improving this situation?

5. Mr. E. has a son and daughter who live in the same part of town as he does. Mr. E. has difficulty walking and is unable to care for his home but he is reluctant to ask his son or daughter for help as he does not want to become a burden to them. He finds it easier to ask the homemaker for assistance rather than asking a family member.

Do you ever feel this way? If so, please explain. If not, how do you think you would feel in Mr. E's situation? Please explain.

6. Mrs. S. is 88 years old and lives alone. She has lived in her home for 35 years and loves to putter around in her garden during the good weather. She is receiving home care service twice a week to assist with her homemaking and her bath as she has a heart condition. Her family have recently insisted that she move into a seniors' lodge as they are worried about her being alone at night. On two occasions Mrs. S. has had to call an ambulance to take her to the hospital during the night because of chest pain.

What do you think is the ideal arrangement for Mrs. S. (e.g. what would you want if you were in the same situation)? At what point do you feel someone should move out of their home and into a nursing home or lodge? Do you think home care should arrange for someone to stay with Mrs. S. during the night (if not mentioned spontaneously by the informant).

7. Mrs. F. has had a recent heart attack and sees her doctor every week to have her blood pressure checked. As well, the home care nurse visits weekly to check her blood pressure and to draw up her insulin syringes. Mrs. F. feels more comfortable talking with her nurse than with her doctor and feels the nurse knows her better because she visits her in her own home.

Do you think Mrs. F. requires a weekly appointment with the doctor and a weekly visit by the nurse? Please explain. How would you make a decision about what is needed in this situation?

8. Mrs. H. accepted a small gift from her homemaker and then found that she was no longer comfortable in giving the homemaker directions and suggestions in relation to her homemaking needs. She finally requested that a different homemaker be sent to her.

Have you ever given a gift to your home care worker(s) or received a gift from her? If so, did this gift giving change your relationship? In what ways? If not, in what ways do you think gift giving might affect your relationship with your home care worker(s)?

9. Mrs. J. had an experience with one homemaker during which she felt "buffaloed" by the homemaker. Mrs. J. felt this way because the homemaker did not ask her what she wanted to have done that day. The homemaker instead proceeded to do what she felt needed to be done and although she did a thorough job her priorities were different than Mrs. J.'s.

Have you ever felt this way? Is it important to you to feel in control of your home?

10. Mrs. K. noticed that her furniture and walls were getting damaged by the vacuum cleaner and claimed the homemaker broke her drapes and seal on her freezer. Although Mrs. K. has discussed these concerns with the homemaker she feels "stuck" with the repairs.

Have you ever noticed any damage done by your homemaker(s). If so, how have you handled this issue. If not, how do you think you might handle it?

APPENDIX F

RATING IN IMPORTANCE

THE CHARACTERISTICS OF HOME CARE WORKERS

Code ____________ Date ________________

Rate in importance the following characteristics of Home Care workers. Circle the number which best represents the importance for you.
Where: 1=unimportant; 2=slightly important; 3=moderately important; and 4=highly important.

Characteristics of homemakers/personal care aids:

- interested in you	1 2 3 4
- thorough	1 2 3 4
- efficient	1 2 3 4
- cheerful manner	1 2 3 4
- trustworthy	1 2 3 4
- punctual	1 2 3 4
- available when needed	1 2 3 4
- consistent (same homemaker)	1 2 3 4
- willing to do extras	1 2 3 4
- willing to take direction from you	1 2 3 4
- sensitive to what needs to be done	1 2 3 4
- willing to become your friend	1 2 3 4
- has time to spend with you	1 2 3 4
- able to communicate well with you	1 2 3 4
- on her first visit seems to know about you when she comes	1 2 3 4

Characteristics of nurses:

- interested in you	1 2 3 4
- knowledgable as a nurse	1 2 3 4
- appears to communicate well with the other home care staff who visit you	1 2 3 4
- able to communicate well with you	1 2 3 4
- available when needed	1 2 3 4
- punctual	1 2 3 4
- provides good nursing care	1 2 3 4
- listens well to you	1 2 3 4
- involves you in the planning of your care	1 2 3 4
- trustworthy	1 2 3 4
- willing to share information about your health status with you	1 2 3 4

- willing to answer your questions	1	2	3	4
- provides valuable information	1	2	3	4
- willing to become your friend	1	2	3	4
- sensitive to your needs	1	2	3	4
- consistent (same nurse)	1	2	3	4
- has time to spend with you	1	2	3	4
- willing to do extras	1	2	3	4
- cheerful manner	1	2	3	4

Characteristics of occupational therapists/physical therapists:

- interested in you	1	2	3	4
- cheerful manner	1	2	3	4
- knowledgable as a therapist	1	2	3	4
- able to communicate well with you	1	2	3	4
- available when needed	1	2	3	4
- punctual	1	2	3	4
- provides good therapy	1	2	3	4
- listens well to you	1	2	3	4
- involves you in planning your therapy and in determining what equipment is needed	1	2	3	4
- willing to share information about your health status with you	1	2	3	4
- willing to become your friend	1	2	3	4
- sensitive to your needs	1	2	3	4
- consistent (same therapist)	1	2	3	4
- has time to spend with you	1	2	3	4
- willing to answer your questions	1	2	3	4
- provides valuable information	1	2	3	4
- trustworthy	1	2	3	4
- willing to do extras	1	2	3	4